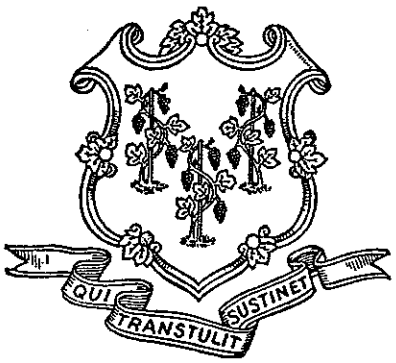
DEPARTMENT OF CHILDREN AND FAMILIES

FOSTER CARE

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1995

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Department of Children and Families

DECEMBER 1995

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EXECUTIVE SUMMARY

The Legislative Program Review and Investigations Committee voted in February 1995 to study the Department of Children and Families (DCF) management, operation, policies, and procedures related to the foster care system. Specifically, the study focused on the department's policies and procedures for the placement of and caring for children in foster family homes. A recent shift in the department's policy emphasizing stricter child protection standards over family reunification and preservation resulted in a dramatic increase in the number of children placed in foster care. However, the program review committee found DCF was unprepared to deal with the influx of children needing out-of-home placements.

The program review committee determined the department's management of foster care is fragmented and disorganized. This is due in large part to the lack of an automated information system capable of tracking available foster care resources. DCF also lacks a coherent and rational organizational design to adequately manage its foster care program. Furthermore, while the department has developed comprehensive policies and procedures relating to foster care and case management, social work practice frequently does not follow policy. Deficiencies in policy implementation were also identified during the committee's review. Departmental neglect of the foster care system and several long-standing contributing factors have resulted in a strained working relationship between DCF and foster parents.

The proposed recommendations will place a stonger emphasis on the foster care system and ensure social work practice follows policy. An organization that will centralize all child-placing responsibilities in one division is also proposed. Improved case management, specifically in the area of collecting and recording information regarding children, is also recommended. Additionally, a process to investigate allegations of abuse or neglect made against licensed foster care providers has been proposed. Finally, it is recommended DCF strengthen its relationship with foster parents and clearly define the foster parents' role in the system.

RECOMMENDATIONS

1. A Division of Child Placement Services shall be created along with the restructuring of the child protection responsibilities into the proposed Division of Child Welfare Services. These two divisions, along with the current Division of Administrative Support, would administer the agency.

The Division of Child Placement Services shall be established for the purpose of coordinating, licensing, providing quality assurance, and managing all placement resources. The division shall be responsible for supervising all resources involved in supporting the agency's fourth level of care, substitute

services. The Division of Child Welfare Services shall be responsible for all child protection functions, regional office operations, and case intake and review.

Specifically, the Division of Child Placement Services shall be responsible for the following:

- *recruiting, training, licensing, and certifying foster homes;*
- *providing contract management and performance monitoring of all private placement resources;*
- *monitoring utilization and tracking all placement resources and providing matching services to the regions for all child placments;*
- *designing a staff training module based upon placement principles and practices to be implemented at the training academy;*
- *providing ongoing technical support to the Connecticut Association of Foster and Adoptive Parents; and*
- *managing all DCF operated residentional facilities and fully integrating resources and placement options into the department's continuum of care model.*

2. *The Department of Children and Families shall develop and implement the use of a child placement portfolio. At a minimum, the child placement portfolio shall contain:*

Current information on the child including:

- *accurate name, birth date, primary language, and religion;*
- *names and addresses of parents, siblings, and significant others (grandparents, etc.);*
- *copies of necessary documentation such as birth certificate, social security number, and medical insurance card;*
- *reason for current placement and legal status;*
- *current permanency goal including expected length of stay, visitation plan, and anticipated date of next administrative case review;*
- *updated medical passport;*

- *name and telephone number of:*
  -assigned social worker and supervisor;
  -child's attorney;
  -educational surrogate (if applicable);
- *a recent photograph of the child;*

Historical and background information:

- *summary of educational needs including a listing of schools attended and special education services required;*
- *placement history including a listing of all placements and dates;*
- *profile of child including characteristics, special behaviors or fears, likes and dislikes (food, clothing, etc.);*
- *summary of social workers assigned to the case; and*

Administrative information:

- *telephone listing of pertinent regional and central office staff;*
- *summary of the rights and responsibilities of foster parents, foster child, birth family, and DCF; and*
- *description of foster parent association, including contact person, hotline telephone number, support group meeting locations and times.*

The child placement portfolio shall be part of the uniform case file of each child involved in an open DCF protection services case, and a copy provided to each foster care provider caring for children placed in the foster care system.

3. *The Division of Quality Assurance shall have the same responsibilities for relative certification as it does for licensing regular foster family homes, including final approval authority.*

4. *The investigation of abuse and neglect allegations against licensed foster care providers shall be conducted by the regional child protective services staff who investigate all other abuse and neglect allegations. The investigations shall be completed within 14 days of referral to Careline.*

The protective services staff shall immediately place a licensed foster home on hold once an investigation is begun, which shall require that no other children are placed in the home and that those children in the home may be removed if the severity of the allegation warrants. Foster care providers shall be immediately notified by protective services investigators of the nature of the allegation and the hold on their license. Investigators shall also notify the assigned regional treatment case worker, supervisor, and matcher, and the necessary staff in the Division of Child Placement Services, including the quality assurance unit, and the Division of Child Welfare Services.

At the end of the investigation period, protective services staff shall produce a finding that an allegation has been: (1) unfounded in which the evidence showed the allegation did not occur; (2) unsubstantiated in which there was insufficient evidence to support the allegation; (3) substantiated; or (4) a regulatory violation.

The finding shall be referred to the Division of Child Placement Services quality assurance unit which shall issue recommendations within 14 days of referral from the investigation unit. The following shall be notified in writing of the recommendations: regional treatment case worker, supervisor, and matcher; necessary staff in the Division of Child Placement Services and Division of Child Welfare Services; and the foster parent. Based on the finding, the quality assurance unit shall take the following action:

- *if the allegation is unfounded or unsubstantiated, the hold is removed at the end of the 14-day investigation period and the license is activated;*

- *if there is a substantiated abuse or neglect allegation or regulatory violation, the hold may be extended for a period of 60 days , during which time the foster parent shall comply with all recommendations. If it is deemed necessary by the quality assurance unit, the hold may be extended for a second 60-day period to allow for compliance to the recommendations. However, noncompliance within the specified time period shall be grounds for license revocation. Once compliance is met, the foster home license shall be activated; or*

- *if the recommendation is license revocation, the quality assurance unit shall immediately suspend the license, remove all foster children placed in the home, and shall proceed with the administrative hearing revocation process.*

5. *To improve the existing working relationship between foster parents and DCF, the department shall clearly define the value and role of the foster parent in the foster care system in policy and procedure. The department shall communicate the change in policy to its staff and insure that compliance is carried out in case mangement and social work practice.*

INTRODUCTION

The Department of Children and Families is responsible for implementing the state's child welfare policies, and providing a variety of direct and funded services to children and their families needing assistance. The department's mission emphasizes child protection and preservation or reunification of the family unit. DCF investigates all reported allegations of child abuse, neglect, or abandonment and has the authority to remove a child from his or her birth home to provide protection.

During the past six years, the department's budget has increased 88 percent and the agency staff by 74 percent. The funding and staffing increases are primarily due to the requirements set forth in the 1993 Juan F. v. O'Neill consent decree, which covers all areas of policy, management, procedures, and operations of DCF.

Scope of Review

The Legislative Program Review and Investigations Committee voted in February 1995 to study the Department of Children and Families. The scope of the study included an evaluation of the management, operation, policy, and practices of the department related to the foster care system. Specifically, the study focused on the department's policies and the procedures for the placement of and caring for children in foster care. The department's compliance with the consent decree mandates, specifically those relating to out-of-home placement, was also evaluated.

It became increasingly clear throughout the committee's study of foster care that societal factors such as poverty, drug and alcohol abuse, single parent families, domestic violence, housing shortages, and unemployment contribute to child abuse, neglect, and abandonment. While these problems are not unique to DCF or Connecticut, their prevalence strains the department's resources and ability to protect the state's children. The committee acknowledged these problems are outside of the sole control of DCF, and focused on the department's use of foster care to remove children from unhealthy, dangerous, and violent situations and dysfunctional families.

Methodology

A variety of sources and research methods were used in conducting the study of the Department of Children and Families. State statutes, DCF policy and procedures, reports, the consent decree, and statistics were reviewed. The DCF training academy programs and staff and foster care provider procedure manuals were also examined. Foster care systems in other states and proposed child placement models were analyzed for comparison to Connecticut. The committee staff also spent time observing DCF child protection investigators, treatment social workers, licensing social workers, and matchers at work to better understand the link between the department and foster children and families.

Structured interviews were held with DCF personnel in the central and six regional offices as well as with private foster care agencies. State and national experts on child welfare and foster care were also interviewed. The committee gathered information from the department, the court-appointed monitor of the consent decree, and the Connecticut Association of Foster and Adoptive Parents (CAFAP) at a panel workshop on foster care and from foster parents at five public hearings conducted a various locations throughout the state during September and October 1995.

In-depth interviews were also held with 42 licensed foster mothers who were randomly chosen from the department's list of all licensed foster parents. The foster mothers voluntarily participated in the interview process and also provided demographic information about themselves and their family. A structured interview instrument was developed and used to solicit information on selected topics.

Report Format

The report is organized into five chapters and contains the committee's findings and recommendations. Chapter I is an overview of the department's mission, mandates, and organizational structure. Chapter II reviews the department's budget and foster care resources, and its use of those resources to place children. Chapter III outlines the licensing, training, and quality assurance functions relating to foster care. Case management and the process of matching a child to an appropriate foster home are presented in Chapter IV. Finally, Chapter V describes the role of the foster parents in caring for children in out-of-home placements and their working relationship with DCF.

A description of the major mandates of the 1993 Juan F. v. O'Neill consent decree is contained in Appendix A. Profiles of six foster mothers, based on in-depth interviews, are contained in Appendix B. A table explaining the rights, roles, and responsibilities of DCF, the foster child, birth parents, and foster care providers is provided in Appendix C.

Agency Comments

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with the opportunity to review and comment on the recommendations prior to the publication of the final report. The response to the committee's report from the Department of Children and Families is contained in Appendix D.

CHAPTER I

OVERVIEW OF THE DEPARTMENT

The Department of Children and Families is the state's key agency in handling children's issues. It is responsible for implementing state child welfare policies relating to foster care, adoption, substance abuse, mental health, health, education, juvenile justice, and abuse and neglect. The department's stated mission is to plan, provide, fund, and coordinate the development of a continuum of integrated services for children and their families guided by the belief that a child's growth and development is best served in his or her own family.

Policy

The DCF mission is based on several principles that guide policy development and direct case work practices and procedures. The department's policy manual states:

- the child is the client;
- children are best raised in families;
- the best interest of the child is of primary consideration;
- services are sensitive to a child's sense of time; and
- services should be home-based or in the least restrictive settings, closest to home, and "culturally competent" (race, religion, and language based).

The stated goals of the Department of Children and Families are to maintain the child within a family setting; to create an integrated community and agency response to department mandates; and to increase efforts to prevent child abuse, neglect, and abandonment. Foster care is a principal program used by the department in meeting these goals and is the focus of this study.

Foster care is defined by departmental policy as a substitute family life experience that provides for a child's needs, such as medical, physical, educational, religious, psychological, and recreational. Foster care is usually a temporary solution that offers a safe and healthy environment when a child's birth family is unable to do so.

The foster care system consists of a variety of different types of placements for children. The least expensive and most commonly used by DCF is placement in the foster family home, which provides a family-setting for those children removed from their homes due to abuse and neglect. The foster family homes are the placement option that most closely meets the department's ideal of keeping the continuity of family life. Group homes, DCF-operated and private residential facilities, independent living arrangements, and relative and adoptive homes are also part of the foster care system.

There are numerous reasons for placing a child in an out-of-home setting, such as a foster family home. They include, but are not limited to, physical and emotional abuse, neglect, and abandonment. In cases reviewed by the program review committee and from the interviews with foster families, children had been placed in foster care because the were badly beaten or were found to be hungry, dirty, inadequately dressed, or lacking routine medical care. Many other children were left unsupervised by their parents in over-crowded and hazardous living conditions. This became especially dangerous when non-related adults had frequent and unsupervised access to young children.

Parental substance abuse had clearly devastated many children's lives. The committee reviewed several cases of drug-addicted babies born to mothers incapable of caring for them as well as cases of children orphaned by their parents' drug abuse. Frequently, children were placed in the custody of DCF when families were not able to control or manage their child's behavior. Poverty is certainly a key factor in most children's lives making it difficult for families to meet basic needs such as food, clothing, or shelter.

Policy conflict. There are two child welfare concepts within the department's mission: child protection and family reunification. DCF attempts to achieve both of these goals through its case management practices. However, many times these goals conflict. The child protection concept asserts that the child is the primary client and services are provided to insure the child's safety and welfare. The needs of the child take precedent over those of the birth family. In many instances, the action taken by DCF on behalf of the child differ from the objectives of the birth family. In almost 9,000 DCF cases, child protection involves out-of-home placement in the foster care system at some point during the treatment process.

Family reunification is part of a larger social service philosophy of preserving birth families. Family reunification is defined as "the planned process of reconnecting children in out-of-home care with their families by means of a variety of services and supports to the children, their families, and their foster parents or other service providers. It aims to help each child and family to achieve and maintain, at any given time, their optimal level of reconnection."[1] The DCF policy manual states family reunification is the overriding goal of the department's intervention in a child's life.

In early 1995, a series of events resulting in the deaths of several children, whose families had been involved with DCF, caused the department to shift its policy focus to child protection from family preservation and reunification. DCF implemented a more aggressive investigation and risk assessment process that resulted in more children being removed from their homes and parents being investigated. This placed a greater demand on foster care resources.

Consistent with the department's policy to protect children, children are often removed from their homes during an investigation of abuse or neglect. Once in foster care, DCF case management

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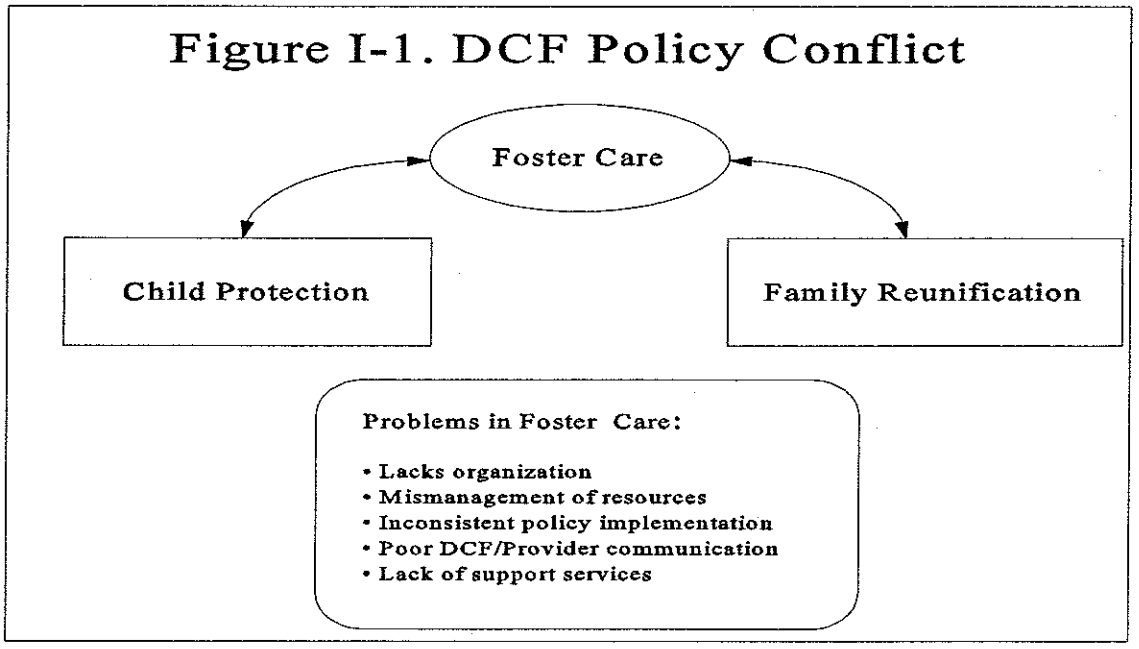
[1]Maluccio, A.N., R. Warsh, B.A. Pine, "Family Reunification: An Overview" in Together Again: Family Reunification in Foster Care (Child Welfare League of America), 1993, p.6

efforts again revolve almost exclusively around family reunification. Although the two objectives, child protection and family reunification, are not necessarily mutually exclusive, DCF clearly emphasizes family reunification to its staff, service providers, and clients through case management procedures. In its current practice, the department has stressed both objectives at different points in a case. Child protection is emphasized during the initial investigation and is the sole reason for placement in foster care at any point during the process. Once treatment begins, family reunification is the goal to either prevent out-of-home placement or to end a child's stay in foster care.

Within this conceptual model, foster care becomes the bridge between child protection and family reunification. Figure I-1 illustrates the strain placed on the foster care system by these opposing objectives. Children move back and forth over this bridge between child protection and reunification. Since the department is highly dependent on foster care a significant emphasis should be placed on how cases are managed. Foster care is a critical component within the overall DCF system and should receive close agency oversight.



As shown, the department is faced with several problems in its foster care system as a result of competing department objectives. Stricter child protection criteria have resulted in an increase in the number of children placed in foster care and have effected the length of time children remain out-of-home. The growing population of children in out-of-home placement has shown deficiencies in the department's ability to both provide appropriate foster care and manage cases effectively. DCF has inadequately identified its placement resources and resorted, in some instances, to using questionable placement practices such as overloading licensed foster homes and placing children in foster homes that have not completed the licensing process.

The family reunification goal also effected the foster care system by focusing case treatment and services on the birth parent(s) instead of the child (client). Based on this conceptualization, foster parents are not viewed by DCF as *families raising children* but rather as *providers of room and board*, which has resulted in an adversarial working relationship between DCF and foster parents. Most of the concerns in this area resulted from the department's narrow view of family reunification, which is limited to full custody of the child by the birth parent(s) and closure of the child protection case. This is the ideal for every child and family, however, DCF must recognize that in some cases complete reunification is not in the child's best interests. In these cases, it must be clear, "that protection implies the need of a child for a sense of permanence and stability, and this may require that, in some cases, parental rights must be terminated"[2] or other forms of contact arranged, such as family visiting that affirm the child's status in the birth family.

Finally, attempting to achieve both child protection and family reunification has caused a conflict between DCF policy and practice in case management by the social work staff. Some crucial DCF policies relating to foster care are not routinely followed by the regional social workers. Regional differences in case management practices also seem to exist. Chapter IV presents a complete analysis of data from case reviews of children in foster care and from the department's automated records, a review of DCF policy, and a review of information collected during in-depth interviews with foster parents aimed at identifying specifically where practice does not follow policy.

Departmental Operations and Organization

Legislative history. The department, formerly known as the Department of Children and Youth Services (DCYS), was created by the General Assembly in 1969 with the authority to administer two juvenile correctional facilities: Long Lane School for girls located in Middletown and the Meriden School for Boys (now closed).

In 1974, the department's mandate was greatly expanded. Legislative changes gradually led the department to take a comprehensive role in all areas of public policy dealing with children and child welfare. Child welfare services were transferred to the department to protect young people from abuse, neglect, and abandonment. The following year mental health services for children and a unified school district were transferred to DCYS.

Beginning in fiscal year 1979, the department initiated community-based child welfare programs, such as parent aide services, child protection teams, and consultation services, which were established in all of the department's service regions. Also in that year, statewide funding for community-based youth service bureaus began.

In 1987, the department instituted a regional management plan to strengthen the community-based services delivery system. Six geographical regions were established, as well as seven sub-

[2]Report of the Independent Panel to Investigate the Death of Emily, 1996, p.5

offices within the regions. In 1988, the regions were mandated to administer substance abuse services for children and youth, adding to the department's continuum of care for children and families.

In 1989, a federal class-action lawsuit, Juan F. v. O'Neill, was filed on behalf of nine minors against DCYS (now DCF). The suit alleged that, in violation of the federal constitution and two federal statutes, the department did not adequately protect the children in its care. The result of the lawsuit was the signing of a consent decree, after a lengthy mediation process, in 1993. The consent decree covered all areas of policy and provided a plan for increasing funding, staffing, and service standards within all areas of the department. The department's compliance with the mandates are overseen by a court-appointed monitor. A detailed description of the consent decree in contained in Appendix A of this report.

Two areas of the consent decree relevant to this study are foster care and the review of cases involving children in out-of-home placements. The consent decree and a subsequent implementation plan required the department to provide licensed foster parents with pre- and in-service training relevant to the job of caring for children and children with special needs, and to facilitate meetings and support groups for foster families. Additionally, DCF was mandated to create the central Office of Family Training and Support (OFTS) and regional family training and support units (FTSU) responsible for the recruitment, orientation, screening, training, and licensing of foster and adoptive families. Finally, the consent decree required that foster care reimbursement rates be increased.

In addressing the case management function for children in out-of-home care, the consent decree mandated, pursuant to federal law, that the department's quality assurance division thoroughly review the cases of children placed in foster care every six months. The review examines the child's treatment plan, services provided, placement, and the permanency goal for the child. Recommendations are then made whether or not to maintain the current treatment plan or to change the services provided the child and family and evaluate the long-term goal for the child.

During a 1994 compliance review, the current monitor found the case reviews to be below the standard and began its own review of a sample of cases involving children in foster care, known as the "100 percent case review". The purpose of this project was to prepare and design a comprehensive case review system. The court monitor has completed its data collection and will issue its report in early 1996. The program review committee's preliminary analysis of the court monitor's data is discussed in Chapter IV.

Technical and minor changes to the department's statutes were implemented during the 1993 legislative session to conform with the consent decree and the agency's restructuring. Also in 1993, the department's name was changed to the Department of Children and Families.

In 1995, legislation shifted the overriding focus from family reunification to child protection. As of October 1, 1995, the department can seek to terminate parental rights after a child has been in its custody for 12 months. Public Act 95-238 reduced the custody period from 18 to 12 months, and made the conditions for extending custody more stringent on the department.

The new law also requires the court to determine whether it is appropriate for DCF to continue efforts to reunify a family. This change was aimed at keeping the court and departmental process focused on a permanent solution for the child rather than restoring, at all costs, the birth family unit. Public Act 95-238 added another requirement to those already in statute for terminating parental rights. Under prior law, the court must find termination of parental rights to: (1) be in the best interests of the child; and (2) that specific grounds exist to warrant termination, such as abandonment or the parent's failure to be rehabilitated. As of October 1, 1995, it must also find that the Department of Children and Families has made reasonable efforts to reunify the family.

During the 1995 session, the legislature also created the Child Fatality Review Panel (P.A. 95-242) to review all DCF cases in which a child died as a result of alleged actions or inaction by the person responsible for his or her care. Beginning in October 1995, the panel will review the circumstances of each case including: cause of death; status of the family with the Department of Children and Families and all other state agencies; policies and procedures; and services provided during the casework. The panel can assist the department in determining the best case practice and identifying resource needs. The Child Fatality Review Panel issues its reports to the commissioner of DCF.

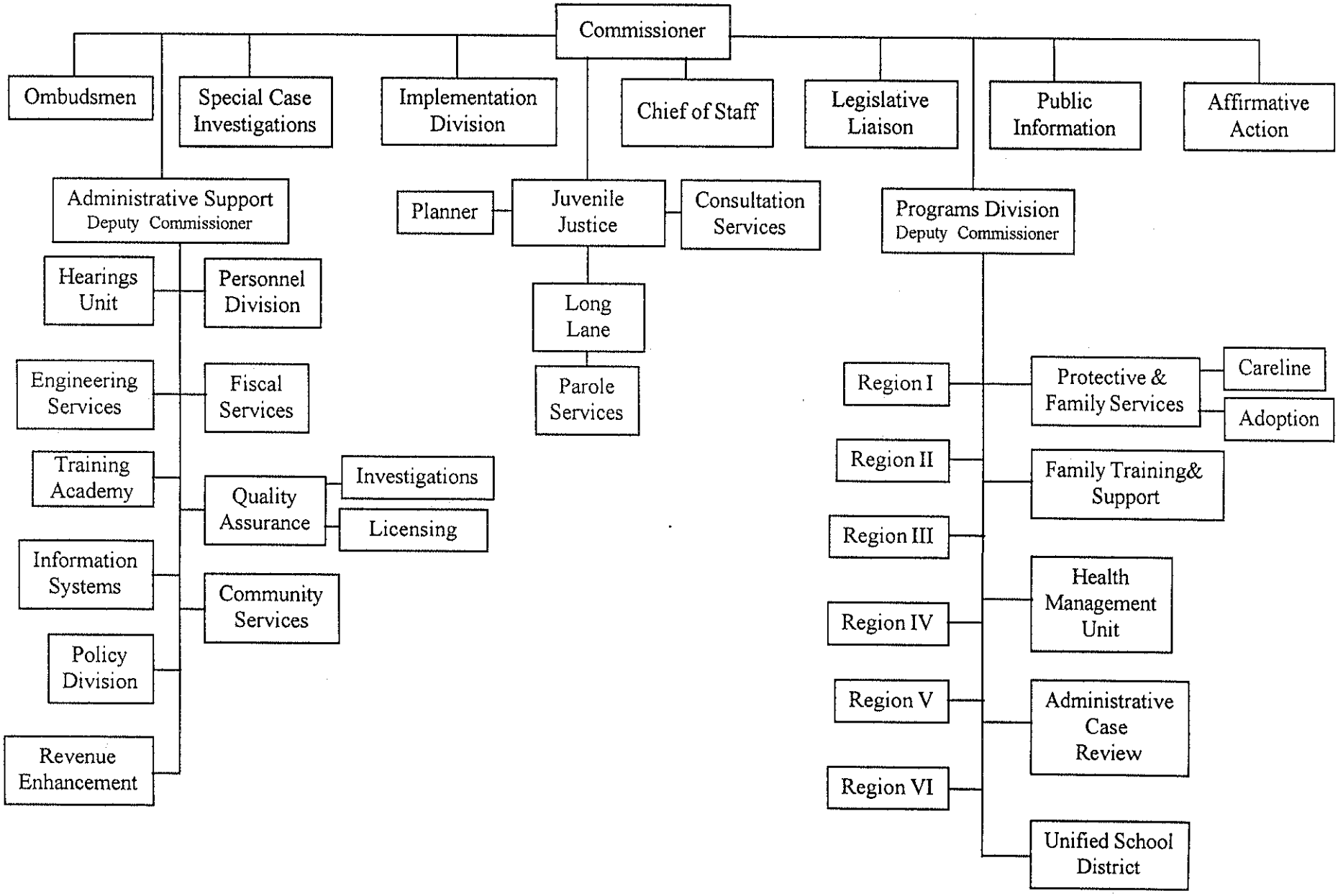
Organization. The Department of Children and Families is organized into three major divisions: (1) Administrative Support; (2) Juvenile Justice; and (3) Programs. For budget and programming purposes, the department delivers services through a four-level continuum of care model. The four levels of care include: (1) Youth and Community Development; (2) Support Services; (3) Supplementary Services; and (4) Substitute Services. The levels of care are administered by the Program Division and Juvenile Justice Division. A fifth program area is reserved for management which is delivered by the Division of Administrative Support.

The major responsibilities of DCF are carried out by the central and regional offices. The current structure of the department is shown in Figure I-2. Two divisions are headed by a deputy commissioner, while juvenile justice reports directly to the commissioner. The commissioner is assisted by several units charged with specific functions, such as: the ombudsman; a case investigation unit that examines the deaths or serious injuries to children in the care of DCF; and an implementation division that oversees compliance with the consent decree.

Division of Administrative Support. This division is responsible for: statewide management and operation of budget preparation and resource allocation; information management systems; policy and program development; personnel; and quality assurance functions such as licensing and investigations of child care facilities. The DCF staff training academy and the community services unit that handles contracts and rate setting are also within the division.

Division of Programs. The programs division administers: children's protective and family services; six regional offices and eight suboffices; family training and support; health management;

Figure I-2. Current DCF Organization



administrative case reviews; and the unified school district. The division's regional offices provide direct services to clients through case management services and child placement services.

Children's protective and family services unit is responsible for four functions. The unit operates Careline, a 24-hour, toll-free, telephone "hotline" for reporting abuse and neglect, as well as providing referral information to families and the general public. The Adoption Resource Exchange finds permanent families for children who are freed for adoption. The administration of the three interstate compacts relating to the appropriate placement and supervision of children across state boundaries is also carried out in this unit. Lastly, the unit is responsible for developing policy for the prevention of child abuse and neglect and providing technical assistance to the regions in this area.

The Department of Children and Families operates six regional offices and eight sub-offices. The regions were created in 1987 to decentralize administrative and programmatic responsibilities, and to increase local involvement in the administration and evaluation of community programs. Prior to this change five regional offices dealt exclusively with protective service investigations and placement of children in foster care.

The regional boundaries are shown in Figure I-3. The six regions and eight suboffices are:

- **Region I**: Bridgeport and Stamford suboffice;
- **Region II**: New Haven and Meriden suboffice;
- **Region III**: Norwich and Middletown suboffice;
- **Region IV**: Hartford and suboffices in Hartford and New Britain;
- **Region V**: Waterbury and suboffices in Danbury and Torrington; and
- **Region VI**: Willimantic and Rockville suboffice.

The regions are responsible for managing all field operations of child protective services. This includes: investigating allegations of abuse and neglect; case management or treatment of open cases involving intact families or families with children in out-of-home placement; and family training and support including foster family recruitment, assessment, licensing, and support programs.

The most recent changes to the department's organizational structure include creation of an office of the ombudsman and a case investigations unit. The transfer of the responsibility for juvenile justice to the commissioner occurred when the department eliminated one deputy commissioner. Also, within the programs division, the office of foster family training and support unit was moved from the children's protective and family services unit to become it own unit, reporting directly to the deputy commissioner.

Juvenile Justice Division. This division is primarily responsible for dealing with children adjudicated as delinquents and placed in the custody of DCF. The division runs Long Lane School and provides parole and counseling services.

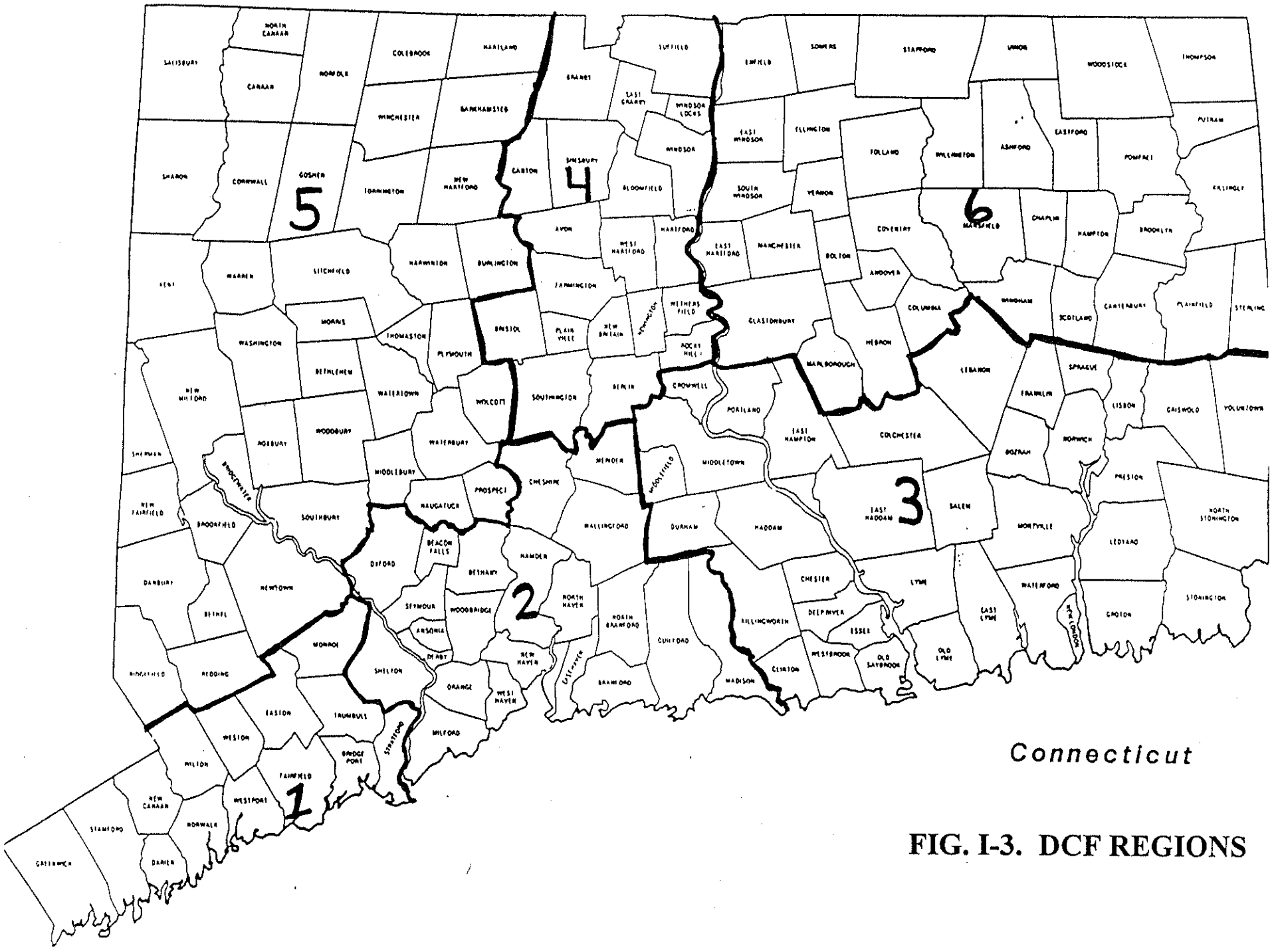
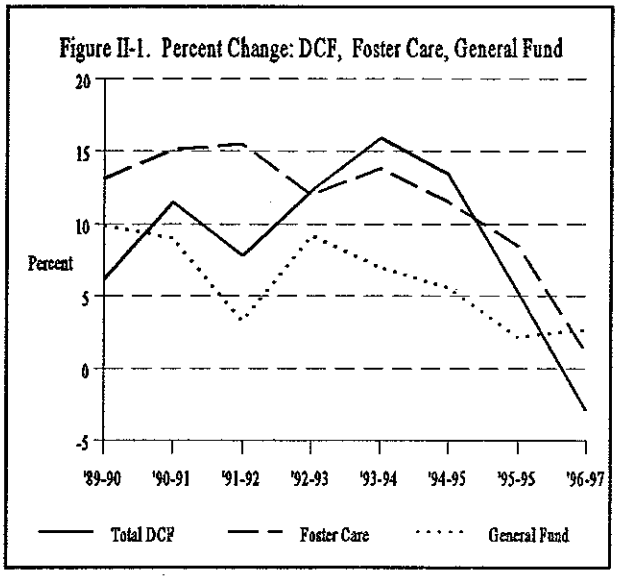


FIG. I-3. DCF REGIONS

CHAPTER II

DCF RESOURCES AND FOSTER CARE CASELOAD

The Department of Children and Families budget and staff increased steadily since fiscal year 1989. From FY 89 to FY 95 the budget grew by 88 percent. The agency staffing increased 74 percent, from 1,761 workers to 3,077. As Figure II-1 and Tables II-2 and II-3 indicate, the department's budget grew faster than the state's general fund every year between FY 91 and FY 95, and at nearly twice the rate in most years. The funding increase has been driven primarily by the requirements set forth in the consent decree. (See Appendix A)



Continuum of Care

As noted earlier, the department's budget is divided into four levels of care and a management level. Each level of care moves progressively toward more involvement of the department into children's lives. The following describes the services provided in each level and the allocation of DCF budgetary resources.

Level I: Youth and Community Development. The first level on the continuum of care is designated as Youth and Community Development. It is designed to promote the healthy functioning of children and youth who are not necessarily a DCF case but who may be at risk of abuse, neglect, mental illness, and drug and alcohol abuse. The services funded at this level, which seek to involve children and youths in their families, at their schools, and in their communities, include: parent education and family-life services; employment training; and information services concerning teenage sexuality, youth suicide, legal rights, and drug abuse. Local youth service bureaus were also supported until the funding for this program was transferred to the Office of Policy and Management Human Services Block Grant in fiscal year 95.

Level II: Support Services. The Support Services Level, the second largest budget category, is designed to: protect children from abuse, neglect, or injury; prevent children's removal from their families and homes; enable children and their families to manage problems; and provide support for family reunification. These services are generally delivered to children and families involved with DCF.

Table II-2. DCF Budget: FY 1990 to FY 1996

Budget Category	88-89	89-90	90-91	91-92	92-93	93-94	94-95	95-96	96-97
Level I	3,048,246	4,271,818	3,925,056	4,433,772	5,314,117	5,117,215	5,280,617	4,023,302	4,023,302
Level II	45,229,845	51,411,381	58,937,809	63,934,958	74,440,111	85,915,654	100,974,353	108,257,455	108,382,453
Level III	2,823,405	2,671,392	3,540,315	2,695,082	2,484,176	1,933,637	3,559,462	4,030,583	4,030,583
Level IV	81,994,899	84,904,814	91,770,119	99,660,147	106,863,845	123,472,978	131,740,184	137,003,678	138,188,767
Management	10,357,977	9,113,832	11,718,844	12,468,076	16,596,537	21,913,733	28,793,150	35,532,711	26,011,264
Total	**$143,454,372**	**$152,373,237**	**$169,892,143**	**$183,192,035**	**$205,698,786**	**$238,353,217**	**$270,347,766**	**$284,631,678**	**$276,420,318**
Level IV: Substitute Services	88-89	89-90	90-91	91-92	92-93	93-94	94-95	95-96	96-97
Foster Family Care	12,890,033	14,577,689	16,776,874	19,379,146	21,695,875	24,693,818	27,543,318	29,896,901	30,219,047
Private Facilities	37,038,302	36,491,090	39,661,188	43,061,785	45,710,214	55,930,466	58,697,917	58,944,788	63,520,165
DCF Facilities	32,066,564	33,836,035	35,332,057	37,219,216	39,457,756	42,848,694	45,498,949	48,161,989	44,449,555
Total	**$81,994,899**	**$84,904,814**	**$91,770,119**	**$99,660,147**	**$106,863,845**	**$123,472,978**	**$131,740,184**	**$137,003,678**	**$138,188,767**

DCF Continuum of Care Levels:

Level I: Youth and Community Development
Level II: Support Services
Level III: Supplementary Services
Level IV: Substitute Services (foster care).

Source: Governor's Budget 1993-1995.

Table II-3. DCF Budget and Staffing Levels: Percent Changes- FY90 to FY96.								
Budget Category	**89-90**	**90-91**	**91-92**	**92-93**	**93-94**	**94-95**	**95-96**	**96-97**
Level I	40.1	-8.1	13.0	19.9	-3.7	3.2	-23.8	0.0
Level II	13.7	14.6	8.5	16.4	15.4	41.0	7.2	0.1
Level III	-5.4	32.5	-23.9	-7.8	-22.2	84.1	13.2	0.0
Level IV	3.5	8.1	8.6	7.2	15.5	-4.4	4.0	0.9
Management	-12.0	28.6	6.4	33.1	32.0	31.4	23.4	-26.8
TOTAL DCF	**6.2**	**11.5**	**7.8**	**12.3**	**15.9**	**13.4**	**5.3**	**-2.9**
General Fund Growth	*9.9*	*9.0*	*3.3*	*9.2*	*7.0*	*5.6*	*2.2*	*2.7*
Level IV*								
Foster Family Care	13.1	15.1	15.5	12.0	13.8	11.5	8.5	1.1
Private Facilities	-1.5	8.7	8.6	6.2	22.4	-16.4	0.4	7.8
DCF Facilities	5.5	4.4	5.3	6.0	8.6	6.2	5.9	-7.7
TOTAL	**3.5**	**8.1**	**8.6**	**7.2**	**15.5**	**-4.4**	**4.0**	**0.9**
Staffing Levels								
TOTAL	**1,757**	**1,835**	**1,908**	**2,234**	**2,566**	**3,077**	**3,039**	**2,937**
Percent Change	-0.2	4.4	4.0	17.1	14.9	19.9	-1.2	-3.4

*Level IV: Substitute Services
Source: Governer's Budget 1993-1995.

This program involves all regional office staffing which provides direct child protective and treatment services to DCF clients. Services delivered by the regional offices include:

- case intake and screening;
- investigations and risk evaluation;
- diagnosis and case planning;
- health care management;
- individual and family counseling;
- crisis intervention;
- case management;
- referrals placements; and

- family reunification.

Level II also includes adoption services, child psychiatric services, and temporary community living. The DCF training academy, a consent decree requirement, is funded and staffed through this program.

Level II funding more than doubled between FY 89 and FY 95, rising from $45 million to $100 million. This funding increase resulted from the significant expansion of staff in the child protective services program from 606 employees in FY 89 to 1,383 in FY 95. The expansion is the result of the Juan F. v. O'Neill consent decree's emphasis on reducing the worker caseload in the regional offices.

Level III: Supplementary Services. The third level on the continuum represents the smallest budget category at $3.5 million for FY 95. This program provides therapeutic care for children who are mentally ill, emotionally disturbed, multiple-handicapped, or engaged in drug or alcohol abuse. The program also funds private day treatment services for children with behavioral problems.

Level IV: Substitute Services. The last level of care is the most intensive involvement of DCF in a child's life. Level IV offers a range of out-of-home placements designed to meet the needs and requirements of children. It also represents the largest funding category at $131 million for FY95.

As noted in Table II-2, on page 14, there are three major foster care programs administered under Level IV: (1) foster family homes; (2) private facilities; and (3) DCF operated facilities. The foster family home program, the primary focus of this study, is currently funded (FY 96) at $29.8 million with 80 staff positions. As Table II-3 shows, there has been a double-digit percentage increase in the foster care budget since FY 89. Even fiscal year 96 increased by 8.5 percent, nearly four times that of the general fund budget.

Private facilities and DCF operated facilities also provide out-of-home placements for children. Each of these categories represents a significant investment of DCF resources. Placement in residential facilities is very expensive. For example, while a foster parent generally receives a minimum of $567 a month for a foster child, the average cost for residential care at the State Receiving Home, a short-term diagnostic facility, is ***$461 a day***. The range in cost results from the intensity of services provided and administrative and staffing costs for the facility.

Private facilities include temporary shelters, transitional and independent living programs, group homes, substance abuse treatment facilities, and residential facilities. Group homes are community-based centers of care that provide room, board, counseling, education, and recreation while residential facilities give intensive and comprehensive care for more difficult children not in need of the more restrictive settings provided by DCF run facilities.

DCF operated facilities treat children for whom substitute services are not available or where more appropriate intensive services in restricted settings are required. Those facilities include

Riverview Hospital for Children and High Meadows which provide psychiatric services for clients with severe behavioral and emotional problems. The State Receiving Home, also a DCF-run facility, provides short-term care and diagnostic services for children who have had difficulties being placed outside the home. Finally, Long Lane School is a Connecticut institution for adjudicated delinquent adolescents who require the most intensive care and custody.

Foster Care Caseload

The Department of Children and Families has experienced a steady increase in its average daily protective services caseload[3] each year since FY 90. The Table II-4 shows the actual number of cases and the percentage change for a five-year period. Though the opening of new cases has

Table II-4. DCF Caseload Trends: FY 90 to FY 94

	FY90	FY91	FY92	FY93	FY94	% Change FY 90 to 94
Avg. Daily Caseload	12,521	13,634	13,414	13,876	14,488	15.7%
Family Cases	5,708	6,369	6,032	6,285	7,245	26.9%
Out-of-Home Placement (Individuals)	4,517	4,504	4,534	4,722	4,976	10.2%
In-Home Cases (Individuals)	2,296	2,761	2,757	2,749	2,302	0.3%
Newly Opened Cases	11,811	11,668	10,870	11,710	11,358	-3.8%
Reopened	4,574	4,516	4,979	6,121	6,707	46.6%
Cases Closed	13,849	13,209	12,847	13,111	12,166	-12.2%
Avg. Number of Cases Served per Month	13,675	14,907	14,484	14,969	16,484	20.5%

Source: DCF 1993-94 Statistical Annual Summary Report

actually declined over this five-year period, the combination of a substantial rise in cases being reopened (46 percent) and a decline in the number of cases closed has led to the average daily and monthly caseload expansion. These two trends have pushed the average monthly caseload up by 20 percent over this five-year period. During the period under analysis, out-of-home placements grew by only 10 percent. However, a 10 percent increase has meant that nearly 500 new placements had to be found for children who were taken out of their homes.

[3]Average daily caseload is computed by taking the total number of protective services cases for each day and dividing by 365 days.

Type of placement. The program review committee obtained a database of all active DCF protective service cases in which a child was in foster care. As of October 1995, 8,811 children were placed in out-of-home care by DCF. Table II-5 provides an overview of the number of children in care and the type of placement. Foster family homes are the most frequently (36 percent) used placement resource. Adoption is the second largest (25 percent) category. As the table indicates, 72 percent of all placements are in either foster family homes, relative homes, or adoption.

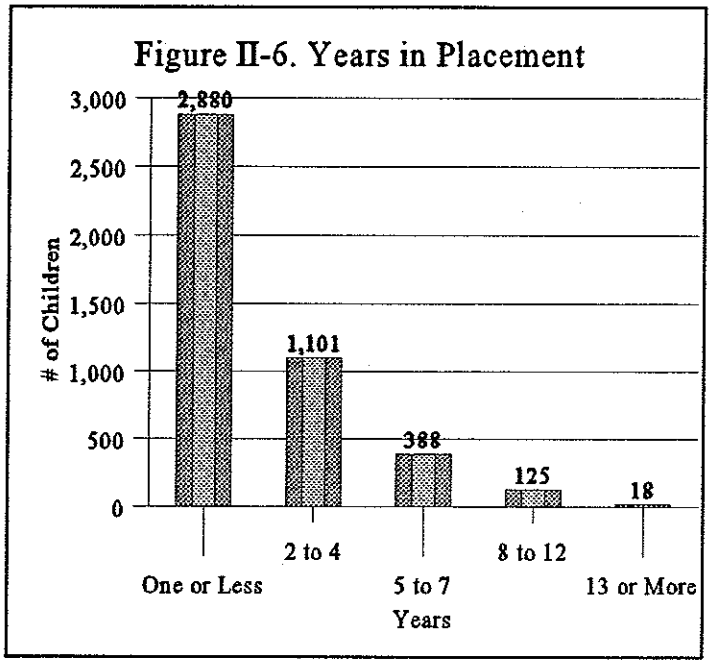
Table II-5. Types of Foster Care Placements.

Type	Number	Percent of Total
Foster Family Home	**3,200**	**36.32%**
Adoption (Subsidized & Pre)	2,169	24.62%
Relative Foster Care	981	11.13%
Private Residential Facilities	904	10.26%
Parent/Guardian	448	5.08%
Long Lane	282	3.20%
Group Home	216	2.45%
Independent Living	159	1.80%
Shelter	143	1.62%
Runaway/Missing	73	0.83%
Hospital	46	0.52%
Receiving Home	45	0.51%
High Meadow	30	0.34%
Riverview	27	0.31%
College	16	0.18%
Other	72	0.82%
Total	**8,811**	**100.00%**

Source: DCF October 1995 Child Placement File.

While this study focuses primarily on foster family homes, other placement options are also used by DCF for child protection when a foster family or relative home is deemed inappropriate. However, the current practice is to place children first with a foster family. As shown in Table II-5, 10 percent of the children are in private residential facilities funded by the department and 5 percent in DCF operated facilities.

Number and Length of Placements. The average length of time for children in all placement options is 1.7 years and nearly two years for those children in foster family care. However, the range in time spent out of the home varies widely as Figure II-6 presents. While 64 percent of the placements are for one year or less, 24 percent of the children are placed into care for two to four years, and 12 percent stay for five or more years.



Another identifiable problem within foster care is children experiencing multiple placements. The placement database indicates only 32 percent of all children are in a single placement, the rest have experienced several successive placements. As shown in the Table II-7, 45 percent of the current children in placement have been moved three or more times. This is problematic for many reasons, including: (1) the emotional, physical, and educational disruption to the children; (2) confusion in the child's birth and foster homes; and (3) staff time and resources used in moving the children.

Foster care "drift", resulting from leaving children in foster care for extended periods of time without setting or working towards a permanency goal, is a significant child welfare problem in Connecticut and nationally. Special efforts need to be taken to closely monitor children placed in foster care especially when there have been multiple placements. Placements need to be well planned and carefully managed by DCF staff if children are expected to thrive.

The department reports that, for those children who are placed out-of-home for six consecutive months or longer, 65 percent were in more than one placement. Twenty-nine percent of those children experienced more than four placements for the time they are committed to DCF.

System capacity. The Department of Children and Families lacks an automated information system to adequately assess the availability of foster care resources. This is particularly apparent with regard to foster family homes and is of critical importance with the rapid and dramatic increase in the number of children needing placement.

Table II-7. Multiple Placements of Children in Foster Care.		
Number of Placements	**Number of Children Effected**	**Percent of Total**
1	574	31.6%
2	436	24.0%
3	272	15.0%
4	141	7.8%
5	95	5.2%
6 to 9	187	10.3%
10 or more	111	6.1%
Total	**1816**	**100.0%**
Source: DCF October 1995 Child Placement File.		

Due to the department's shift in policy and practice regarding the assessment of risk to children, there has been an increase of 3,304 children placed in all foster care placement options between January through October 1995. This represents a 38 percent increase in the number of foster care placements, from 5,506 in January to 8,811 in October, 1995. Comparatively, placements in foster family homes has increased from 2,659 to 3,200 during this same period. The increase is a direct result of the department's more aggressive policy of removing children from families where abuse and neglect are alleged and a trend toward leaving children in foster care longer until adequate family treatment has been received.

To estimate foster care resources and system capacity, the program review committee obtained the foster care provider payment database for the month of October 1995. These data were analyzed to determine the availability of foster family homes. The data were examined for two factors: (1) the number of licensed homes and beds within each home; and (2) the number of homes and beds being utilized. Table II-8 details system resources based upon foster care payments. Along the top row of the table are the number of beds utilized by each licensed home (0 to 7). Down the side are the number of licensed beds in each home (0 to 5). Homes are licensed for a specific number of beds. Homes can be either operating at licensed capacity, operating over licensed capacity, or have empty beds (under licensed capacity). A number of homes shown in the table are licensed at 0 capacity which means they are unlicensed. The numbers corresponding to the top row (bed utilization) and side column (licensed beds) represent the number of homes falling within each category.

The data indicate there were 2,050 licensed homes with 4,112 beds for which 3,740 payments were made. Program review committee also found there were 785 payments made for as many beds in 533 unlicensed homes. At the same time unlicensed beds were being used, the data show more

than 1,500 beds in licensed homes were not being used. In addition, 283 homes were operating over capacity (by 417 beds). The table indicates that 20 percent of the homes being used during October 1995 were unlicensed. There are 4,112 beds both licensed and unlicensed in 2,583 homes (licensed and unlicensed).

These three variables: (1) unlicensed homes with beds filled with children; (2) licensed homes operating below capacity; and (3) licensed homes exceeding capacity indicate DCF is unable to determine what placement resources are available. These factors also suggest inefficient and ineffective management and utilization of a critical department resource. Further, an inability to properly identify resources strongly contributes to children being improperly placed and thus contributes to children and families experiencing multiple placements.

For this period of time, the data indicate there were an ample number of open beds in licensed homes but many foster homes were operating in excess of capacity. There are, however, a number of reasons for the discrepancies. Some homes may elect not to take any foster children for a period of time but wish to remain licensed. Others may be licensed for more children than they are currently ready to take. However, it is suspected there are more than 1,100 beds not assigned any children. This may be more indicative of mismanagement of resources than a lack of foster homes.

There are a number of situations in which licensed foster parents have no children placed in their home, such as a birth, illness, death, marriage, or divorce in the family or a move to a new home or family vacation during which time it would be difficult to care for a foster child. Some foster parents take time off between placements, especially if they care for medically fragile or special needs children. In some situations, foster parents have retired from foster care prior to the expiration of the current license and DCF records list the home as active. Also, DCF policy prohibits the placement of children in homes on hold or under suspension due to allegations of abuse or neglect. The department's record keeping is not sufficiently updated to identify these reasons.

Given the 38 percent increase in foster care placements over the last nine months, it is not surprising that some foster family homes are operating at over-capacity. Foster homes can receive an "administrative exception" that allows them to exceed their licensed capacity if they are willing and able to take additional children. This is frequently done to prevent children from being separated from their siblings.

Placing children out of their home is the most intensive and disruptive level of involvement a state agency can have in a family and child's life, no matter how sensitively it is handled. Any out-of-home placement of a child needs to be well planned and carefully monitored.

Table II-8. DCF Utilization of Licensed and Unlicensed Foster Family Homes. October 1995.													
Bed Utilization		**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	Totals	Total Beds Licensed	Unlicensed Beds	Total Lic/Unlic. Homes
Unlicensed Beds	**0**	0	358	121	39	11	1	2	1			785	533
Licensed Beds	**1**	*313*	317	41	16	6	1	0	0		694		694
	2	*229*	*161*	216	44	23	5	0	0		1,356		678
	3	*108*	*77*	*129*	196	92	40	10	3		1,965		655
	4	*5*	*1*	*0*	*1*	9	1	1	0		72		18
	5	*1*	*0*	*2*	*0*	*0*	2	0	0		25		5
	Total Beds Used	**0**	**914**	**1,018**	**888**	**564**	**250**	**78**	**28**	**3,740**	**4,112**		**2,583**
	Over Lic. Capacity	0	0	41	76	156	100	32	12	417			
	Under Lic Capacity	*1,120*	*318*	*135*	*1*	*0*	*0*	*0*	*0*	*1,574*			
	At Lic. Capacity	0	317	432	588	36	10	0	0	1,383			

Source: DCF Vendor Payment Database. October 1995.

Adequate information regarding contact with children, biological parents, and foster parents is extremely important. As noted earlier, placement is the bridge between child protection and family reunification. Creating a strong child welfare system requires the placement bridge to be well managed and vigilantly monitored. The program review committee found the Department of Children and Families lacks a coherent organizational design to adequately care for children in placement.

A recent consultant's study of the department's organization and staffing presented findings and recommendations that focused on clarifying organizational responsibilities, strengthening management, improving effectiveness and efficiency, and providing greater support and resources for regional offices.[4] Specifically, the study by Peat Marwick found the commissioner's span of control is too great while at same time excludes direct control of important areas. One of those excluded areas was the Health and Mental Health Services Unit. The consultants identified this unit as "one of the largest and most important areas of the agency". It is responsible for administering DCF residential facilities such as the state receiving and psychiatric units. Programs within this category expend more than $48 million in budget resources. The report noted that one important function -- quality assurance (discussed in Chapter III) -- appears to be "misplaced". The Division of Quality Assurance is responsible for two important functions relating to foster care: licensing and investigations.

The consultant also found "too much of the department's functional responsibility is concentrated under the deputy commissioner of programs". The deputy commissioner is currently responsible for 75 percent of the agency's staff and funding. In addition all six regions report directly to the deputy commissioner, who is also responsible for the management of foster care, private placement facilities, and state institutions.

The program review committee concurs with many of the findings of the Peat Marwick management study. However, the committee differs somewhat on the needed organizational design to improve the agency's functioning. The program review committee believes the agency needs to clearly focus on placement of children. Nearly half the agency's budget is used to place children in homes and facilities that will properly meet their needs, yet, there is no single bureau within the agency responsible for this most important function-- out-of-home placement. As noted by the consultants, even the licensing of foster homes, located within quality assurance, is linked to agency administration rather than program implementation.

Currently, the department has a fragmented system of child placement that lacks a clear and rational organizational design. **Therefore, the Legislative Program Review and Investigations Committee recommends a Division of Child Placement Services shall be created along with the restructuring of the child protection responsibilities into the proposed Division of Child Welfare Services. These two divisions, along with the current Division of Administrative Support, would administer the agency.**

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[4] Organization and Staffing for the Connecticut Department of Children and Families, KPMG Peat Marwick LLP, October 1995.

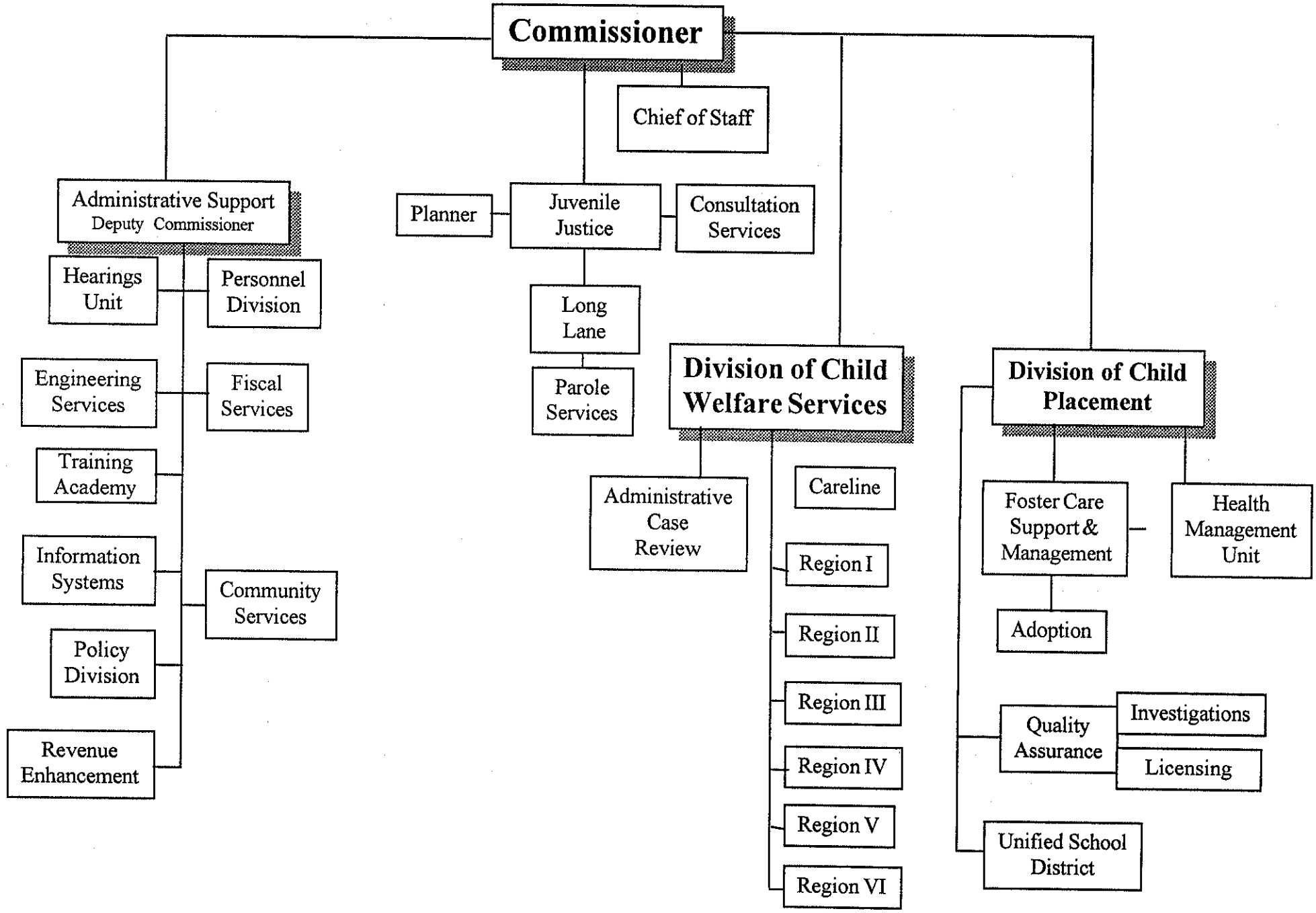
The Division of Child Placement Services shall be established for the purpose of coordinating, licensing, providing quality assurance, and managing all placement resources. The division shall be responsible for supervising all resources involved in supporting the agency's fourth level of care, substitute services. The Division of Child Welfare Services shall be responsible for all child protection functions, regional office operations, and case intake and review.

Specifically, the Division of Child Placement Services shall be responsible for the following:

- **recruiting, training, licensing, and certifying foster homes;**
- **providing contract management and performance monitoring of all private placement resources;**
- **monitoring utilization and tracking all placement resources and providing matching services to the regions for all child placements;**
- **designing a staff training module based upon placement principles and practices to be implemented at the training academy;**
- **providing ongoing technical support to the Connecticut Association of Foster and Adoptive Parents; and**
- **managing all DCF operated facilities and fully integrating resource and placement options into the department's continuum of care model.**

The recommended reorganization of the Department of Children and Families is provided in Figure II-9. As shown, the existing Programs Division is divided into two separate divisions: the Division of Child Placement Services and the Division of Child Welfare Services. Each of these new divisions shall report to a deputy commissioner.

Figure II-9. Proposed DCF Organization



CHAPTER III

Licensing and Quality Assurance

The DCF Office of Family Training and Support and the regional family and training support units are responsible for the recruitment, home study, training, matching, and support of foster and adoptive families. The central family training and support office serves to coordinate, plan, and support the regional units to ensure uniformity in the implementation of foster care and adoption initiatives statewide. The regional units directly provide these services to the foster and adoptive families and are administratively supervised by regional offices staff.

The department's role in foster care extends to: establishing ongoing marketing and recruitment plans for foster parents; developing uniform assessment, preparation, and training procedures for applicants; and licensing enough quality homes to meet each child's needs for physical and mental health, cultural and racial identity, and permanency planning. The department is mandated to develop standardized post-licensing training, certification, support and retention services, and a 24-hour help line for foster families. In an effort to retain foster parents, the department's policy requires support for the regional foster family through group and individual meetings and for the statewide foster parents' association. However, DCF is currently reviewing its role in the training and support of foster care providers to determine the best use of its existing resources.

Foster Care Licensing

Regulations. By regulation, a foster home is defined as a private family home caring for not more than five children, except: (1) when local ordinances specify a lesser number; (2) no more than two children under two may be cared for, including foster and biological children; or (3) no more than three non-ambulatory children incapable of self-preservation can be served. All homes and facilities must be licensed by the Department of Children and Families and may be suspended, revoked, or denied in accordance with regulations.

The regulations set forth guidelines for the physical requirements of the home, health and medical treatment of the child, and other services. In addition, there are regulations governing disciplinary practices, clothing allowances, chores, and responsibilities of the child. Currently, foster care regulations are a part of the regulatory system of child care facilities. In an effort to address the specific concerns and needs of foster parents and the department, DCF revised its foster care regulations. The proposed regulations will be an expanded version of the existing regulations, to be less vague, and address areas of concern specific to foster parents and foster care. The department expects to propose the revised regulations to the General Assembly during the 1996 legislative session.

All families providing foster care for the Department of Children and Families, except relatives, must be licensed annually. Relative foster parents are certified rather than licensed by DCF.

Prospective adoptive parents are approved for licensing by DCF. The approval status must also be renewed annually until a child is placed in the home. Currently, the department is using a standardized assessment process to decide the suitability for licensing foster care and adoption applicants. Relatives are also assessed but the process is simpler and less intensive.

The licensing process begins with the recruitment of interested families and ends in placement of the foster child in a licensed home. The primary purposes of licensing foster homes are to:

- protect children in out-of-home care from abuse and neglect;
- assure parents and the community that the person, facility, or agency meets specific requirements;
- improve the quality of child care through regulation and consultation; and
- ensure that all service providers (including foster parents) meet established standards of quality.

Recruitment and assessment. In 1995, the Department of Children and Families initiated a statewide marketing campaign to recruit families interested in providing foster care. Before this, the department recruited through its regional offices by conducting outreach programs and providing information to special interest groups, such as schools, hospitals, churches, and civic organizations. Historically, the department relied heavily on active foster parents recruiting other interested individuals into the program.

The new marketing campaign is coordinated through the Office of Family Training and Support, and consists of television and radio advertisements, billboards and posters, brochures, and souvenirs such as key chains, magnets, stickers, balloons, and shirts. Regional offices are also supplied with the material and are continuing their efforts at recruiting.

The assessment of interested individuals for suitability as foster parents begins with the initial contact to the department by the prospective foster parent. The department maintains a centralized routing system that will transfer a caller to the appropriate regional FTSU office for further information. DCF mails the individual promotional information on foster care and invites the parent to the next scheduled open house conducted by the regional offices. The department also uses this opportunity to initially assess those in attendance.

Open house gatherings are organized and held by the regional family training and support units and are scheduled at various locations throughout the regions. DCF social workers conduct the informational meetings and distribute the assessment application. FTSU social workers identify prospective applicants and counsel those individuals who do not appear to meet the department's foster care criteria to discontinue the application process voluntarily.

Figure III-1 illustrates the foster parent assessment and licensing process. As noted earlier, in the spring of 1995, the department became more stringent in its investigations of abuse and neglect

allegations, which resulted in more children entering the foster care system. This increase in the number of children needing homes forced a change in the licensing process.

The department shifted its resources and energies from training applicants to become foster parents to initially assessing and identifying those applicants suitable to provide care without training. The OFTS estimates it now takes approximately four months from initial inquiry by an applicant to licensure. The goal of OFTS is to reduce that to three months, including the six-week group assessment process, and to focus all foster parent training at the in-service level after the first year of experience.

The new assessment process uses an instrument, developed by a consultant, to gather relevant information on the families, including their views on child rearing, the relationship between the parents and their children, and their opinions on foster care. The assessment instrument is completed by the foster parent(s). Applicants are also required to submit additional information and documentation, including a criminal history check, financial history, and medical status. The licensing social worker then reviews the documentation and makes a recommendation to approve or deny licensing to the Quality Assurance Division.

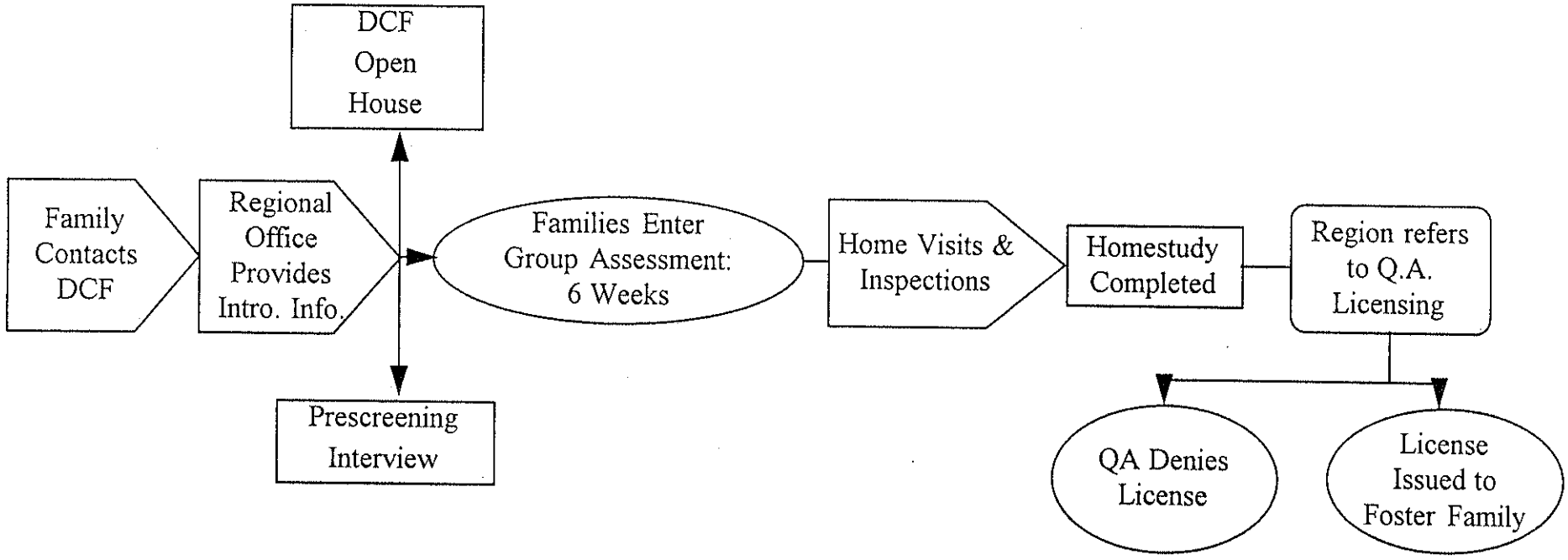
The group assessment process is also an opportunity for the department to inform applicants about the child welfare system. While the primary goal of the process is assessment, the licensing worker provides prospective foster parents with information to make an informed decision about foster care and the knowledge to work within the child care system. However, this is not a training program for new foster parents.

Prospective foster parents are assessed in groups of approximately 12 to 15 families. The group portion of the assessment process consists of six weekly sessions, each lasting about two hours. However, due to the increased demand for foster homes, the regions are reducing the number of weeks by increasing the number of sessions each week. The group meetings provide an opportunity for the regional FTSU social worker to inform the applicants about specific aspects of and issues in foster care along with a follow-up question-and-answer session. The group meetings are co-led by a FTSU licensing social worker and a foster parent.

The content of material provided to prospective foster parents during the six-week group session is uniform and structured throughout all regions. The central office of family training and support has adapted the curriculum based on the canceled foster parent training program. The topics covered during the sessions are as follows:

- **Week 1:** Introduction to DCF and exploring foster parent motivation;
- **Week 2:** The treatment team and understanding birth parents;
- **Week 3:** Understanding separation and loss;
- **Week 4:** Sexual issues and concerns (focusing on children's behavior not sexual abuse);

Figure III-1. Foster Family Licensing Process



- **Week 5:** Effective child guidance (corporal punishment policy and issues); and
- **Week 6:** Foster parent panel.

The foster parent panel, held in week six, gives applicants an opportunity to listen to the experiences of licensed foster parents. The panel members are asked to answer a series of structured questions covering topics such as: the decision to accept a child for placement; child's adjustment to the home; typical behavior problems; experiences with birth parent visits; working with caseworkers; the joys and hardest part of foster care; and how to say goodbye to foster children.

Prior to the current group assessment process used to license foster parents, the department relied on a two-phase system. That system performed an initial assessment study of the applicant using an earlier version of the existing assessment tool. Prospective foster parents who were deemed suitable, where then invited to a training group. The groups were developed based on similarities between the foster parents, such as the types or age ranges of children for whom the parents were willing to provide foster care. The training program initially required families to attend a weekly training session for eight weeks.

However, the separate training program was then reduced to six weeks, then four weeks, and now has been eliminated. Due to staffing shortages and the high demand for licensed foster homes, the department will rely on the post-licensing training to prepare foster parents, which is discussed later in this chapter. Some training was offered on a limited basis during 1995, and DCF contracted with a private provider, the Connecticut Association of Foster and Adoptive Parents, to implement specific training programs and support services for foster parents.

The assessment process for prospective adoptive parents is the same as that for foster parents. However, adoptive parents are *approved for licensure* and must annually renew their approval status while waiting for the placement of a child. Licensed foster parents wishing to adopt a child do not have to complete the full assessment process again but must update their information with the department. All prospective adoptive parents, including those licensed as foster parents, are subject to a family study by the Probate Court. Once a child is placed, the family is licensed until the adoption is finalized by the Probate Court.

Home visits. Also during the assessment process, prospective foster and adoptive families are subject to home visits and inspections for compliance to physical structure regulations. The home visits are conducted by the regional FTSU licensing social worker. On average, a family applying for a foster parent license will be visited four times: a personal interview prior to beginning the group assessment process and a minimum of three visits. The personal interview is conducted by a licensing social worker and provides the applicant with an overview of the foster care system, assessment and licensing process, and support and training as well as allows the worker to make a determination of any serious impediments to licensure. During the three home visits each parent or adult in the home and children are interviewed individually and then the family as a whole.

There are several objectives to the home visits, including: (1) an assessment of the family's home life; (2) an opportunity for the social worker to discuss parenting issues and the family's expectations of foster care; (3) an opportunity to address any concerns that may have arisen during the group assessment sessions; and (4) to inspect the physical conditions of the home and ensure compliance to regulations.

After completion of the group sessions, all required paperwork, and home visits, the licensing social worker submits a report on the suitability of the applicant to become a licensed foster parent. The report contains the rating from the assessment instrument, a narrative report, and a recommendation. The final report must be approved by the FTSU supervisor and the regional program supervisor. Once approved, the foster parent application is forwarded to the licensing unit of the Division of Quality Assurance.

Licensing. Currently, the Division of Quality Assurance deals with foster care. The division was created in 1978 to monitor compliance with federal standards, state regulations, policy, and procedures, as well as to serve as a problem solving vehicle for the department. The division is headed by a director, and consists of four main units: licensing of foster care homes and facilities; investigation of allegations against foster care providers of abuse and neglect; program review and evaluation; and quality assurance. Each function has staff assigned to that area.

The licensing unit is responsible for the development of licensing policy, procedures, and regulations, and the integrity of the department's licensing functions. Direct licensing responsibilities of the unit include issuing licenses to: (1) child care facilities, including foster and adoptive homes; (2) in-state child placing agencies; (3) permanent family residences; and (4) extended day treatment programs. The licensing unit also approves out-of-state child placing agencies who place children with Connecticut families. The licensing unit also oversees the regional licensing responsibilities and has the final authority to approve or deny a license. The unit processes and issues the licenses and monitors capacity changes or other adjustments to licenses, such as change in marital status, birth of a child, and change of address.

Prior to approval, the licensing unit ensures the applicant meets the criteria specified in regulation and DCF policy by reviewing the regional office record. The regional FTSU is responsible for compiling and maintaining the foster family record which consists of the assessment instrument, required documentation, and social worker reports. Once approved, the initial foster parent license is issued for a period of one year and specifies the bed capacity (one to five beds) and the type of care to be provided.

The licensing unit is also responsible for the annual relicensing of foster homes, which evaluates the foster care service provided in the home. During relicensing a quality assurance worker will interview the foster parent, inspect the home, and review the case records and care provided by the foster parent. A criminal history check is also done annually on each adult living in the foster home and caring for foster children.

Relicensure is again for a period of one year. If during relicensing quality assurance identifies a violation or problem in the home, it can issue a provisional license valid for 60 days. Departmental policy allows up to six consecutive provisional 60-day licenses (one year) to be issued to a home working to meet the standard and regulation requirements. If the home comes into compliance, it may be reissued a one-year license or the department may revoke the license if the home does not meet the standards and criteria.

The program review committee found the department's regular foster family assessment and licensing process to be effective. The assessment instrument, purchased from a consultant by DCF, is a useful tool for FTSU staff and allows for information to be gathered in an organized and uniform manner. The process ensures oversight and approval of regional licensing by the Quality Assurance Division. Final approval by a central office division guards against licensing substandard or unsuitable foster homes solely to meet the placement needs of the regional offices.

However, the program review committee found a major impediment to the department's recruiting and licensing capabilities. As discussed earlier in Chapter II, the department lacks the ability to adequately track its available resources and to assess its future needs in foster care. DCF has currently over-extended foster parents by placing more children in many homes than they are licensed for while other foster homes remain empty or under capacity. Even more disturbing, is the department's placement of children in unlicensed homes.

The committee believes the recommended Child Placement Division should coordinate all aspects of out-of-home placement in foster care, from needs assessment, recruiting, and foster parent retention to resource availability and placement. In successfully implementing this recommendation, the department must consider all aspects of foster care, including licensing of foster family homes.

Relative certification. DCF has defined a relative in regulation as "an adult who is related to a child by blood, marriage, or adoption descended from a common ancestor not more than three generations removed." Recent legislation (P.A. 94-216), exempted relatives providing foster care from statutory and DCF licensing requirements and implemented a certification procedure. The department can place a child in the unlicensed home of a relative for a period of 45 days if a home visit is conducted, a basic assessment is completed, and a criminal history check of all adults living in the home is done. Relative foster parents must be certified for all placements continuing beyond the 45 days.

The purpose of the home visit and interview, conducted during the initial 45 days of placement by the child's treatment case worker, is to collect and record information on general family demographics; emergency contacts; family composition and structure; criminal history of all adults in the home; and medical status of family members. Additional documentation must be obtained through fingerprinting of all adults living in the home to obtain any criminal history and a check of DCF protective service files for any prior involvement with the department. Relative foster parents must also comply with the regulations as set out in the statutes, however, they may meet lower criteria than regular foster parents. For example, DCF may waive compliance in specific areas if there

is general compliance and understanding of the regulations by the relative. Finally, relative foster parents must agree to follow departmental policy for providing care and using discipline. All relative foster parent records are maintained in the child's case file.

The treatment social worker's recommendation on certification must be approved by the regional social worker and program supervisors. The Quality Assurance Division has no authority or role in the certification process. It is notified a relative certification has been issued and tracks certification renewal dates. Relative foster care certification must be renewed annually.

Foster care rates. Foster families are reimbursed on a monthly basis for expenses incurred on behalf of a foster child. The Department of Children and Families rate structure is based on a reimbursement standard recommended by the United States Department of Agriculture (USDA). As required by the consent decree, the DCF rates represent 100 percent of the USDA standard.

There are four types of foster care: regular; relative; CHOICE; and medically fragile. The reimbursement rates are based on the type of care and, for regular and relative foster care, by the age of the foster child. The monthly reimbursement rates for children placed in a regular foster family homes, that do not provide any special or specific treatment or care, are as follows:

- $567 for a child up to the age of five years ($18.90 per diem);
- $586 for a child between the ages of six and 11 years ($19.53 per diem); and
- $637 for a child 12 years or older ($21.23 per diem).

The monthly reimbursement rates total $6,805 for children up to five years; $7,035 for six to 11 year olds; and for those 12 years and older $7,645 annually. The monthly foster care reimbursement includes the major budgetary components and expenses surrounding the child, such as housing, food, transportation, clothing, spending allowance, fees for extracurricular activities, school supplies, and vacations or summer camp. The department allows for an initial clothing allowance of $300 per child to provide an adequate supply of seasonal clothing at the time of first placement into the system.

For any child placed by Careline staff on an emergency basis, the foster family will receive an additional payment of $10 per day. This adjustment will remain in effect until the assigned social worker authorizes the placement and basic rate.

When a child is placed by DCF in the licensed or certified home of a relative, that relative can receive the standard foster care reimbursement rate appropriate to the child's age or Aid to Families with Dependent Children (AFDC) assistance through the Department of Social Services in lieu of DCF payment. If AFDC is received, DCF considers the child's needs to be fully met.

The department maintains a third placement option called the Caring Home Offering Individualized Cooperative Environments (CHOICE) that is a foster care program for children with special needs. The foster parents receive special training prior to placement of the foster child, are highly skilled, and are provided with strong support services to provide treatment in a family setting. The children placed in a CHOICE home are between the ages of 3 to 16 years and have emotional, behavioral social, educational and/or psychological problems, mental health needs, or other special needs. These children have usually failed to succeed at a regular foster family, residential, or group home, and other less intensive resources have been insufficient or are unavailable.

The reimbursement rate for a CHOICE placement is $1,200 per month. CHOICE providers receive $300 per month for an unoccupied bed for a period of up to three months to ensure availability for DCF.

The fourth category of foster care placement is for medically fragile children. These are children who have been medically determined to have a diagnosable, enduring, life threatening condition; a physical impairment caused by that condition; HIV positive; or AIDS. Medically fragile children require substantial, medically prescribed care because their condition has interfered or limited their performance at home, in school, in the community, or during activities.

Foster parents caring for medically fragile children must meet specific training, certification, and licensing requirements. The reimbursement rate for this care is $1,200 per month and any extraordinary expenses not covered under medical insurance.

Training. The Juan F. v. O'Neill consent decree and DCF policy manual require licensed foster parents to participate in a structured post-licensing training program. The consent decree mandated a 45-hour program during the first year of licensure, consisting of 36 hours of parenting concepts and skills followed by nine hours of understanding the courts' role and medical issues in foster care and the roles and responsibilities in the system. The consent decree further required foster parents to attend 12 hours of training in the second year of licensure and six hours every year thereafter. All foster parents were required to attend the training despite the length of time they had been licensed by the department.

This training program was never fully implemented by DCF, although some curriculum has been developed and offered to foster parents. The department has developed a 12-week training course for both foster parents and protective service social workers that has been offered on a limited basis in some regions. The goal is to have the two groups receive the same training and to strengthen their working relationship. DCF implemented less stringent training requirements for two reasons: (1) staffing resources were shifted from the foster parent training and support function to recruitment and licensing because of the rapid increase in the number of children needing out-of-home placement; and (2) the department found the consent decree mandate to be unrealistic and burdensome on the regional offices' staff and foster parents.

Support for foster families. The central office and regional units of family training and support were created by the consent decree. The main objective in creating the OFTS and its regional FTSU was to provide foster parents with a departmental system of support outside of the protective service and treatment work for the child. Although the support network was implemented, the foster family support policy has not been written. The system was developed by the DCF central office. During 1995, the department reduced its role in foster parent support and placed a greater emphasis on child protection services, which necessitated a shift of its resources and staff to the licensing functions.

The FTSU social workers, called support workers, were to be available and responsive to the concerns and needs of foster parents. In addition to their responsibilities for individual families, the support workers offered support group meetings and training sessions. Prior to the recent shift in resources within FTSU from support to licensing functions, each support worker had a caseload of approximately 75 foster families. Now, each region is operating with fewer support workers for all foster families in that area, resulting in substantially increased caseloads.

Another DCF support service for foster parents is respite care. Respite care provides a scheduled period of rest and relief from ongoing parental responsibilities while foster children are cared for by an alternative provider with no disruption to the foster parent's reimbursement. Respite care is a temporary, department-managed babysitting service with the purpose of decreasing placement disruptions. The reimbursement rate for respite care is $20 per day and is paid directly to the provider.

Respite care is provided by licensed foster parents who do not currently have a child in placement or are under their licensed bed capacity. Foster parents licensed for one year and who have provided continuous care for foster children during that year are eligible for up to eight days of respite annually. The regional matcher is responsible for pairing the foster parent and respite care provider. However, the foster parent is responsible for all other arrangements such as scheduling, providing transportation, and providing necessary information for the child's care.

All licensed foster parents automatically become members of the Connecticut Association of Foster and Adoptive Parents, a statewide professional association funded by DCF. CAFAP is run as a non-profit organization and is administered by an elected board of directors, consisting of CAFAP members and social work professionals from private service providers.

The mission of the association is to promote coordination and communication between foster and adoptive parents and state and private agencies serving children. With the reduction of the department's role in family training and support, CAFAP received additional funds to hire an executive director and program administrator to oversee an expansion of its role in providing support services to foster parents. Also, DCF recently contracted with the association to develop and implement programs and services aimed at helping foster parents, such as a "buddy system" pairing an experienced foster family with a newly licensed one, a 24-hour telephone help line to respond to questions and crisis situations, and foster parent training.

DCF has not developed or provided post-licensing training for foster parents as required by the consent decree. The department has not placed a high priority on training, and has reassigned staff from training to other functions. The program review committee concludes DCF must provide training to foster parents to be in compliance with the consent decree, and focus on and invest in foster parents if it is to strengthen its foster care system as previously recommended in this report. Training is one way to insure foster parents understand the missions and goals of out-of-home care and follow DCF policy and procedures. Training also would help to improve the strained working relationship that currently exists between foster parents and DCF staff.

The recommended Child Placement Division will coordinate and supervise all aspects of foster care including the training and support of foster parents. The objective of the Child Placement Division is to stress the importance of the foster care system by focusing departmental resources and staff on its management and organization.

Division of Quality Assurance

Licensing unit. Although recruitment and assessment of prospective foster and adoptive parents takes place in the regions, a variety of other licensing activity is centralized and handled directly by quality assurance, such as license renewals, denials, suspensions, revocations, capacity changes, and other license adjustments. Relicensure of foster homes and other child care facilities occurs annually and involves a review of the homes' compliance to the department's regulations and policy for care and conditions in the home.

Relicensing of foster homes. The relicensing process, conducted by quality assurance staff, is a shortened version of the initial licensing process previously described. However, unlike initial licensing, the quality assurance unit has the sole decision-making authority to issue a renewal.

Foster homes and other child care facilities are required to report any changes in the status of the home or of the provider to the licensing unit. Situations that must be reported include changes in marital, financial, or health status; births or deaths, criminal arrests and convictions; and alterations to the physical condition of the home or a move to a new location. The licensing unit is responsible for determining if the changes comply with regulations and policy. In cases where the family or physical conditions of the home are in noncompliance, the licensing unit may issue a provisional license.

The quality assurance division has the authority to deny relicensure to a foster home or a facility for failure to comply with regulation requirements or due to unacceptable changes in the conditions of the license. The licensee is given 30 days to correct the cited violation or the license revocation process begins. The quality assurance division can extend the 30-day period or a provisional license if the foster home has made a good faith effort to comply. Foster homes have the right to request an administrative review hearing if denied licensure.

Quality assurance does not have a role in the recertification process for relative foster parents. The renewal process, like the initial certification, is conducted in the regional offices.

The program review committee found relative certification to be a questionable practice that potentionally may compromise the department's child protection standards and services. Originally, the department used relative placements as temporary solutions to provide the birth family time to address the problems resulting in DCF intervention and then to reunify the child with his or her birth family, or until a foster care placement was found for the child. With the rapid increase in the number of children coming into the foster care system, relative placements became accessible and available options for placement. The department requested the statutory change from licensing to certification for relative foster parents in an attempt to: (1) reduce its licensing workload; and (2) offer relatives an incentive by lowering the standards and making the approval process easier. However, in light of the fact that DCF has been placing children in unlicensed foster homes, there is the possibility it will continue this questionable practice in relative foster homes. Also, lowering the criteria for relatives potentially jeopardizes the department's ability to provide safe homes for children.

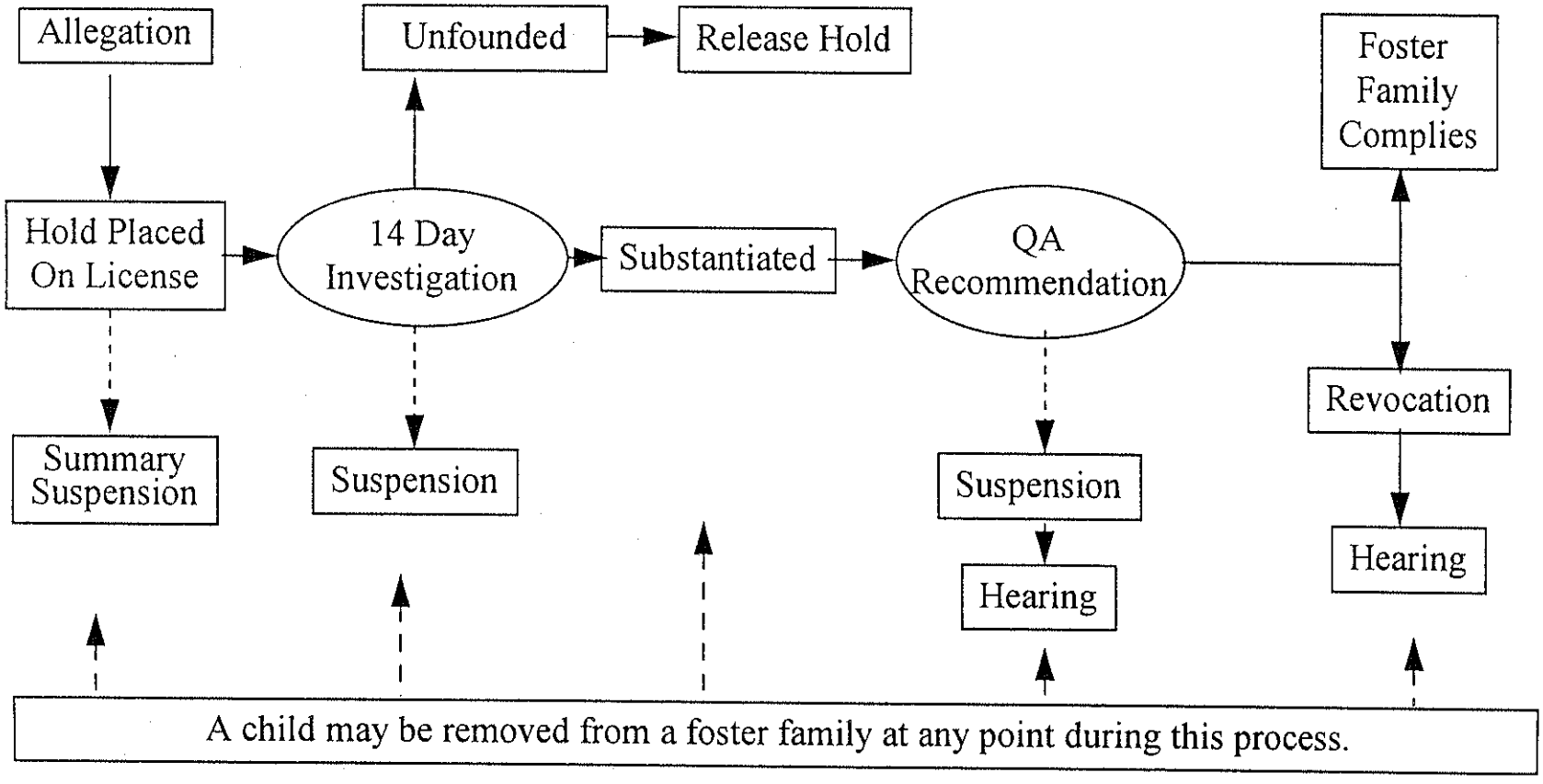
The relative certification process, although in compliance with the law, is deficient in meeting the spirit of the law. There is no centralized oversight of regional practice, approval authority, and issuance of certifications. The Division of Quality Assurance has no role in the relative certification process. The quality assurance division is responsible for providing a general monitoring function of regulations, policies, and procedures, and is an essential component to the operation of any state agency. **It is, therefore, recommended the Division of Quality Assurance shall have the same responsibilities for relative certification as it does for licensing, including approval authority.**

Furthermore, the Department of Children and Families should provide assurances and safeguards that relative certification will be practiced consistently throughout the regions. Because reimbursement payments are made on the same scale to relative and regular foster parents, DCF has a responsibility to insure that children in placement are receiving the same care.

Investigation unit. This unit investigates all allegations of abuse and neglect to a DCF child in a licensed foster home or facility. Allegations against licensed foster homes or facilities are referred to the quality assurance division from Careline or regional social workers. These are the only cases investigated by this unit. All other allegations involving biological or adoptive families are investigated by regional protective services social workers. However, the investigation and casework process done by both units is similar.

Investigation. Figure III-2 represents the typical process for the investigation of an allegation against a licensed foster home or facility. Quality assurance investigators are required to complete an investigation within 14 days of the referral. The investigation usually involves interviews with the referral source, alleged victim, other children in the home, foster parents or staff of child care facility, DCF protective service workers, family training and support social workers, and the alleged perpetrator. If appropriate, school or day care personnel, medical providers, community service providers, and relatives, neighbors or police may also be interviewed.

Figure III-2. Investigation of Foster Homes



Evidence is collected, including prior allegations of abuse and neglect, investigations, police and medical records. The child's case file and the licensed foster parent's file are reviewed. The investigators also review the home or facility for compliance with the regulations and policy. The allegation can also be referred to local police.

The investigation unit is responsible for finding whether or not an allegation is substantiated or unfounded. It is also responsible for making recommendations, ranging from additional foster parent training or counseling to restricting the type (age, sex, special needs) or number of children placed in the home, to the most severe: license revocation. All action on recommendations, except revocation, are the responsibility of the regional office. Quality assurance does not have a role in the enforcement of its recommendation until the relicensing period, during which time the investigation report will be reviewed and compliance by the foster family will be considered. In those cases where license revocation is recommended, quality assurance will suspend the license and follow the administrative hearing process set out in policy and statutes.

Hold on license. Foster children are not necessarily removed from a foster home or child care facility during an investigation. The decision to remove the child is based on the nature and severity of the allegation. For example, an allegation that a foster parent failed to comply with the department's policy on discipline by hitting or spanking a child or withholding food as punishment may not result in immediate removal, especially if it was an initial occurance and was classified as non-severe. However, an allegation of sexual abuse or serious bodily injury would most likely require removal of the child from the foster home.

In all investigation cases, the license to provide foster care or operate a child care facility is placed on hold, which is an administrative action. A hold is placed on the license by the regional office and requires that no additional children be placed in that home or facility during the course of the investigation. The hold is valid for an indefinite period of time and no due process requirements are afforded to licensed providers. Again, the children in that home identified as the victims may or may not be removed. The hold is removed by the regional office at the conclusion of the investigation. The quality assurance investigation unit has no authority in this process.

Quality assurance recommendations. The quality assurance investigation unit is responsible for making findings that the allegation is substantiated or unfounded. A report containing findings and recommendations is submitted. In cases where the allegation is substantiated, the investigator makes recommendations to either revoke or continue licensure. Recommendations to continue licensure may also include additional training, counseling, reducing the number of children placed in the home, or only placing a certain type of child in the home. The report is forwarded to the regional office, which has discretion in the enforcement of the recommendations. It is at this point that the hold placed against the license is removed and placements may be reactivated.

It should be noted that the quality assurance division does not have a role in the enforcement of its recommendation until the relicensing period, during which time the investigation report will be

reviewed. The family's compliance with the recommendation will be a determining factor for relicensure.

Suspension. In addition to placing a foster care license on hold, the Department of Children and Families has another level of authority that allows for the discontinuation of services until the license revocation process is started: suspension. This is the only way in which quality assurance can halt placement activity in or remove a child from a foster home or facility before revocation of the license.

The division of quality assurance may suspend a foster home or child care facility license at three points during the investigation process. Although the suspension can occur at different time for a variety of reasons, the process and effect on the license is the same. Initially, a foster home or facility may be placed under suspension immediately upon referral based on the severity of the allegation resulting in a crisis situation. All children in the home are removed immediately. This is called a summary suspension and is in effect until the next licensing activity, such as a revocation.

A license suspension can also be ordered by the quality assurance division when the on-going investigation indicates more serious action, than a hold, must be taken. In most cases this constitutes removal of the child, which may not have occurred during the hold process. The suspension allows for the immediate removal of the foster child without a formal removal hearing afforded to the foster family or child care facility. The suspension is valid until the next licensing activity.

The third opportunity is at the conclusion of the investigation. If the investigation substantiates the allegation and the recommendation is to revoke the license, the quality assurance division will immediately place the home or facility under suspension. All foster children will be removed and the suspension will remain in effect until the next licensing activity.

Foster homes and facilities placed under suspension are entitled to an administrative hearing within 10 days of issuance of the suspension and a revocation hearing must be scheduled within 30 days. The decision to uphold the suspension and order the revocation process to begin or to overturn the department's action is made during the administrative hearing process. In either outcome, DCF can order the revocation of the license. If the suspension is overturned, the department must afford the foster family and the child the opportunity to reunite the placement.

Revocation. During the revocation of license process, the foster child will remain in the home or facility unless:

- the license is suspended due to health, safety, or the welfare of the child and the suspension has been upheld during the hearing process;
- there is clear and present danger to the child; or
- the department is awarded an order of temporary custody from the court.

If any one of the three conditions occur the child may be removed prior to the hearing process and placed elsewhere.

A foster family may also consent to the removal of the child, which does not require a removal hearing. However, if the child has been residing in the foster home for a period of one year or more, the foster family can request a removal hearing to determine if discontinuing the placement is in the child's best interests. The removal hearing is held prior to the revocation hearing.

The department may revoke a foster care license for non-compliance with the regulations. The licensed family is notified of the cited violation and provided with a brief description of the circumstances of the case. The family must request a revocation hearing within 15 days of notification or the license revocation will take effect. If a hearing is requested, it must be scheduled within 30 days.

At an administrative hearing for license revocation, the department is represented by the Office of the Attorney General. The foster family or facility may have legal representation present but legal services are not provided by DCF. If any foster children are involved in the case, they are generally not present at the hearing. Foster families may appeal a revocation decision to the Superior Court.

A foster care license does not have to be suspended prior to the revocation process. However, in most revocation cases, the foster children have already been removed either through suspension of the license, other placement reasons, or upon request by the foster family or child.

The program review committee found that the current practice of investigating abuse and neglect allegations against foster homes is confusing for DCF staff and foster parents. The investigation process of child abuse or neglect allegations is the same whether the allegations are against a birth parent, relative, or foster parent. It is a repetitive effort on the part of DCF to maintain separate investigation units in child protection services and quality assurance, and there is no basis to differentiate between abuse allegations made against a foster home or birth home. An allegation of abuse or neglect is severe no matter who the alleged perpetrator is and must be swiftly handled by DCF.

Furthermore, the current investigation process does not include a scale of authority, other than license revocation, for the department to enforce its recommendations on foster care providers. In fiscal year 1994-95, the department investigated abuse and neglect allegations against 307 foster care homes and revoked 26 foster care licenses.

To strengthen the quality assurance process, the Legislative Program Review and Investigations Committee recommends the investigation of abuse and neglect allegations against licensed foster care providers be conducted by the regional child protective services staff who investigate all other abuse and neglect allegations. The investigations shall be completed within 14 days of referral to Careline.

The protective services staff shall immediately place a licensed foster home on hold once an investigation is begun, which will require that no other children are placed in the home and that those children in the home may be removed if the severity of the allegation warrants. Foster care providers shall be immediately notified by protective service investigators of the nature of the allegation and the hold on their license. Investigators shall also notify the assigned regional treatment case worker, supervisor, and matcher and the necessary staff in the Child Protection Division, including the quality assurance unit, and the Division of Child Welfare Services.

At the end of the investigation period, protective service staff shall produce a finding that an allegation has been: (1) unfounded in which the evidence showed the allegation did not occur; (2) unsubstantiated in which there was insufficient evidence to support the allegation; (3) substantiated; or (4) a regulatory violation.

The findings shall be referred to the Child Protection Division quality assurance unit which shall issue recommendations within 14 days of referral from the child protection services unit. The following shall be notified in writing of the recommendations: regional treatment case worker, supervisor, and matcher; necessary staff in the Child Protection Division; and the foster parent. Based on the findings, quality assurance unit shall take the following action:

- **if the allegation is unfounded or unsubstantiated, the hold is removed at the end of the 14-day investigation period and the license is activated; or**

- **if there is a substantiated abuse and neglect allegation, or regulatory violation, the hold may be extended for a period of 60 days during which time the foster parent shall comply with all recommendations. If it is deemed necessary by quality assurance, the hold may be extended for a second 60-day period to allow for compliance to the recommendations. However, noncompliance within the specified time period shall be grounds for license revocation. Once compliance is met, the foster home license shall be activated; or**

- **if the recommendation is license revocation, the quality assurance unit shall immediately suspend the license, remove all foster children placed in the home, and shall proceed with the administrative hearing revocation process.**

CHAPTER IV

FOSTER CARE PROGRAM OPERATION

The Department of Children and Families is a multi-service agency receiving clients from a number of agencies and systems for a variety of reasons any one of which may lead to foster care. The usual point of entry into foster care for most children is through DCF protective services. Pursuant to state and federal law, it is the department's policy to make reasonable efforts to prevent or eliminate the need for a child's removal by providing services to strengthen the family. However, despite intervention, certain situations make out-of-home placement necessary.

Removal Methods

The four primary ways in which children are removed from their homes are a 96-hour hold, an Order of Temporary Custody (by the court), court commitment to DCF, or voluntary placement.

A *96-hour hold* is used by DCF when serious conditions pose imminent danger to a child. A 96-hour hold can be granted by a regional director, DCF commissioner, or medical personnel in a hospital setting. A 96-hour hold is a very serious decision because it may be invoked at any time without the parents' permission or prior knowledge. It is not a decision that is reviewed by the court. Therefore, the length of the removal is brief and the criteria to hold is very strict.

The maximum time a child can be held is 96 hours unless canceled by the authority that invoked it. During this period of time, the commissioner of DCF or the hospital becomes the child's guardian and DCF continues to gather information to determine either the continuing need for placement, or the ability of the child to return home. If it is determined that the child should remain in care, DCF must file a petition for an order of temporary custody with the court before the 96 hours run out.

The *Order of Temporary Custody (OTC)* is granted by the court after filing of a petition by DCF based on facts showing that a child is in imminent danger of serious physical harm. When it is determined that the child is in need of court protection and the order is granted, the commissioner of DCF becomes the child's guardian for a period not to exceed 10 days. Within the 10 day limit of an OTC, a show cause hearing is held and the parents, through legal representation, "show cause" why the child should be returned to their care. The child and DCF also have legal representation present. If it is decided that DCF maintain custody, the court continues the custody for 30 days. If DCF custody is denied, the child is returned home. In either case, a full hearing is scheduled by the court within 30 days to determine whether or not the allegations can be substantiated warranting the child's commitment to DCF care.

The third way a child can be removed from home is through *commitment* proceedings. Commitment is used when there is no imminent danger to the child, and therefore, cannot be removed

until there is a court hearing. A child is committed when a court finds, through a neglect petition filed by DCF, the child is in need of protection. DCF may be granted care and custody of a child for a period not to exceed 12 months.

Before the end of the 12-month commitment, DCF can petition for the following:

- revocation, which is a return of the child to the home;
- extension of the commitment for another 12 month period; or
- termination of parental rights.

The fourth method of removal is *voluntary placement*. A child is voluntarily placed when a parent requests removal from the home for a period of up to 90 days. This type of removal is usually used for short-term problems within the family, such as children who run away, have psychiatric, emotional, or health problems, or exhibit unusual or uncontrolable behavior. The parent retains all rights to and responsibilities for the child. At the request of the parent, the child must be returned immediately to the home.

DCF Protective Service Case

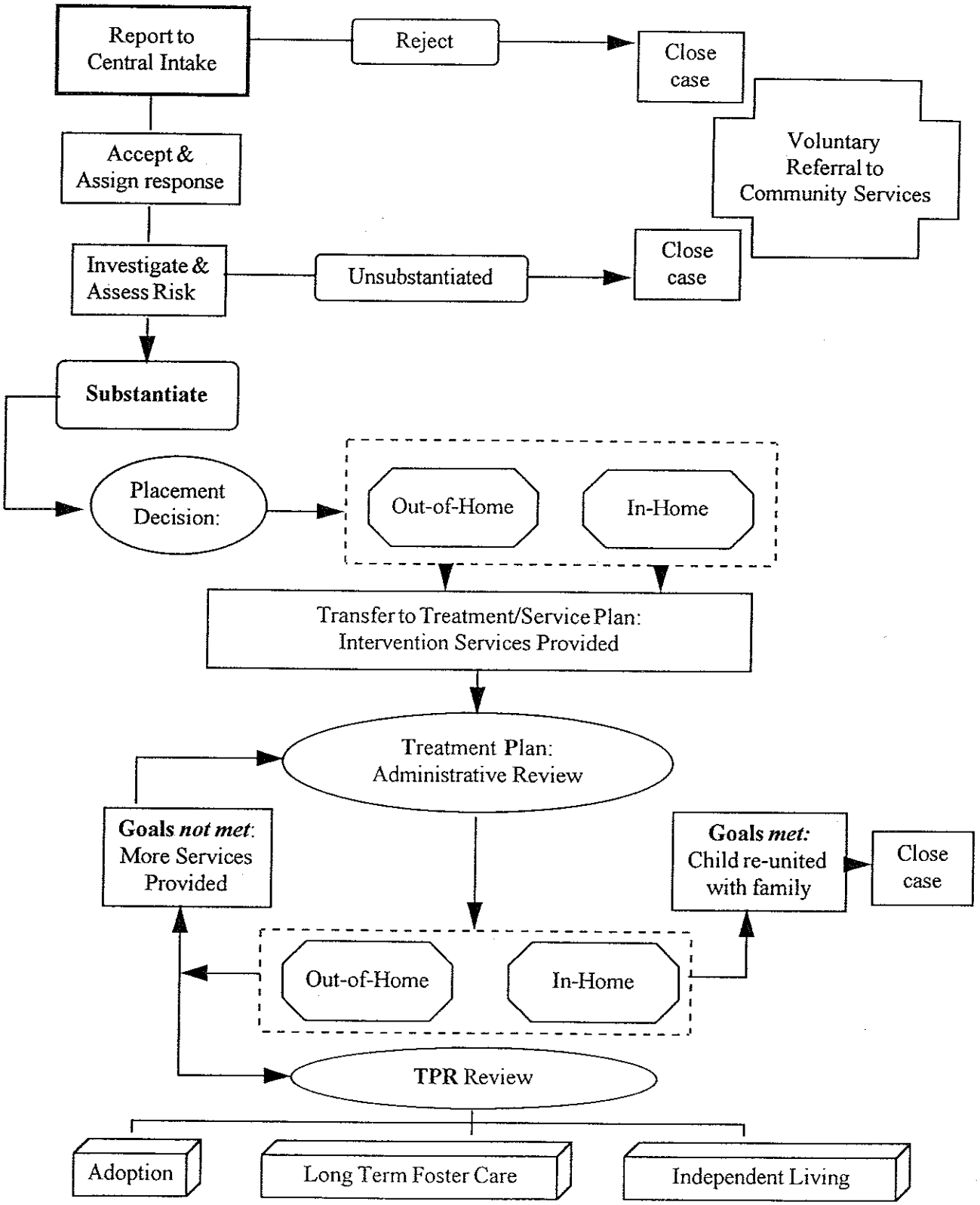
As previously mentioned, the most common entry point into the foster care system is from a protective services case. Protective Services is a specialized service extended to families on behalf of children under 18 years of age who are neglected, abused, or abandoned. It is distinguished from other services provided by DCF in that it is primarily involuntary. The main goals of protective services are to ensure that children are protected from physical harm and that parents can function independently and adequately in providing care for their children. DCF protective service involvement with a family may be as brief as 24 hours or as long as several years. A flowchart illustrating the process of a DCF case is shown in Figure IV-1. The diagram begins with the initial referral and continues through treatment to the close of a case.

Referral. Entry to the DCF protective service system begins with a report of an allegation. The allegation may come from a variety of sources such as mandated reporters (i.e., doctors, teachers, day care workers) as well as from any member of the public. All reports are received by DCF's Central Intake Unit (also known as CARELINE) which is operated 24 hours a day, 7 days a week. As illustrated by the flowchart, this is the first point at which a DCF decision is made.

The Intake Unit decides whether a report is accepted for investigation. It is the responsibility of the intake unit to collect and assess information about a report and determine an appropriate response time. To make this determination the intake unit uses three tools:

- **operational definitions:** used to distinguish between reports alleging abuse, neglect, or at- risk cases;
- **data collection form:** allows the intake worker to compile the basic information needed to start and complete an investigation; and

Figure IV-1. DCF Case Process



- **response time matrix:** used to determined the appropriate response time for beginning an investigation.

At a minimum, the referral or allegation must: provide sufficient identifying information to locate the child and family; involve a child under 18 years of age; and be in reference to abusive and/or neglectful behavior by the parents that have an effect on the child. The worker checks the central registry and computer system to obtain any prior or current case information. If necessary, the worker will notify the police.

If the intake worker determines the report is not acceptable, a supervisor's approval of non-acceptance must be obtained. The reasons for non-acceptance are documented and maintained for 90 days before being purged from the file. All accepted reports are assigned a priority status. The following table lists the priority statuses and required response times.

Table IV-2. Priority Status and Response Time.

CATEGORY	RESPONSE TIME	*EXAMPLES.....*
Imminent Danger	within 3 hours	*Child requires medical Rx for injury and prior confirmed abuse/neglect reports*
Emergency	within same workday	*Child with chronic medical or emotional problem and refusal or failure to obtain medical or psychiatric Rx.*
Severe	within 24 hours	*Leaving child unsupervised or unprotected for excessive period and no prior reports.*
Non-severe	within 3 working days	*General allegation of parental drug abuse and no prior reports.*

Source: DCF Policy Manual.

Once a report is accepted and prioritized, it is submitted to a supervisor for review and approval. If a report designated *imminent danger*, *emergency*, or *severe* is made after-hours requiring immediate response, the investigation is initiated by the intake unit staff. Otherwise, the intake unit ensures that accepted reports are transmitted to the appropriate regional office or Quality Assurance Unit if the report concerns allegation against a DCF licensed facility.

Investigation. The investigation phase continues the process of gathering facts and information already begun during intake. Information gathered during the investigation is used to determine whether or not the allegation can be substantiated. Recently, the department changed its time frames for completion of an investigation. Beginning July 1995, all investigations should be completed within 14 days. Prior to the change in policy, investigations categorized as *imminent*

danger, emergency, or *severe* were to be completed within 30 days. *Non-severe* cases were required to be completed within 45 days.

Within the investigation time frame, the investigator must make all required contacts specified by policy. These include contacts with the child, parent(s) and if appropriate, day care personnel, preschool /school personnel, medical provider, any known community service providers, relatives, neighbors, or police.

Although a case may take days to thoroughly investigate, this does not preclude DCF from immediate intervention. Risk assessment is a continuous process in which the social worker and supervisor weigh the factors to determine the safety for a particular child within the family. If there is probable cause to believe the child has suffered serious physical illness or injury or is in physical danger from his or her surroundings, and immediate removal is necessary to insure the child's safety, the commissioner may authorize a 96-hour hold to remove the child without parental consent.

As noted in Figure IV-1, on page 47, there are two investigation dispositions: substantiated or not substantiated. A substantiated report initiates a placement decision and is immediately transferred to the Treatment Unit for development of a treatment plan. An unsubstantiated report does not mean that the abuse or neglect did not occur. It simply means that DCF did not find observable or credible evidence to document the abuse. In this situation, the department has no legal basis for further intervention unless the parents voluntarily accept services.

At the end of an investigation, all documentation, results, and case disposition are filed in a written report. The results are then submitted to the central registry and computer system for entry within five days of completion. The information is also used to begin the process of developing a treatment plan to address the needs and provide services to the child and family.

Placement Process. According to DCF policy, whenever possible removal of a child should not be considered until other alternatives are explored (i.e., relative placement or perpetrator is removed from the home). Once a decision is made that the child must be placed in a safer more appropriate setting, the social worker and supervisor must discuss:

- the danger to the child;
- the child's needs that have not been met;
- any special needs the child may have;
- support mechanisms for the family available in the community;
- available placement options; and
- the number of siblings in the family and possible impact on them.

Once removal has occurred, placement for the child must be sought. As stated previously, whenever possible a child will be placed with relatives or extended family if they can meet the needs of the child. However, if this is not possible, it is the department's responsibility to locate an appropriate placement. It is the department's policy to place a child in the least restrictive, most

family-like setting which is geographically close to the child's own home. The process of locating this placement is known as "matching." Each region has a "matcher" whose responsibility is to place the child in a home. The matcher is the initial link between the foster care provider and the child's social worker.

Each DCF region has one full time matcher except Hartford which has two. Every region operates a "back-up system" whereby another social worker is available to assist the full time matcher in the event that several requests for placement come in at the same time. In addition to locating regular foster placements, matchers also have the responsibility of arranging respite care for foster families who request it. Table IV-3 illustrates each region's matching activity for September and October, 1995.

Table IV-3. Number of Foster Care Requests Received in Sept./Oct. 1995.

Region	I	II	III	IV	V	VI	TOTAL
September	75	58	78	92	51	65	419
October	73	66	83	141	56	88	507

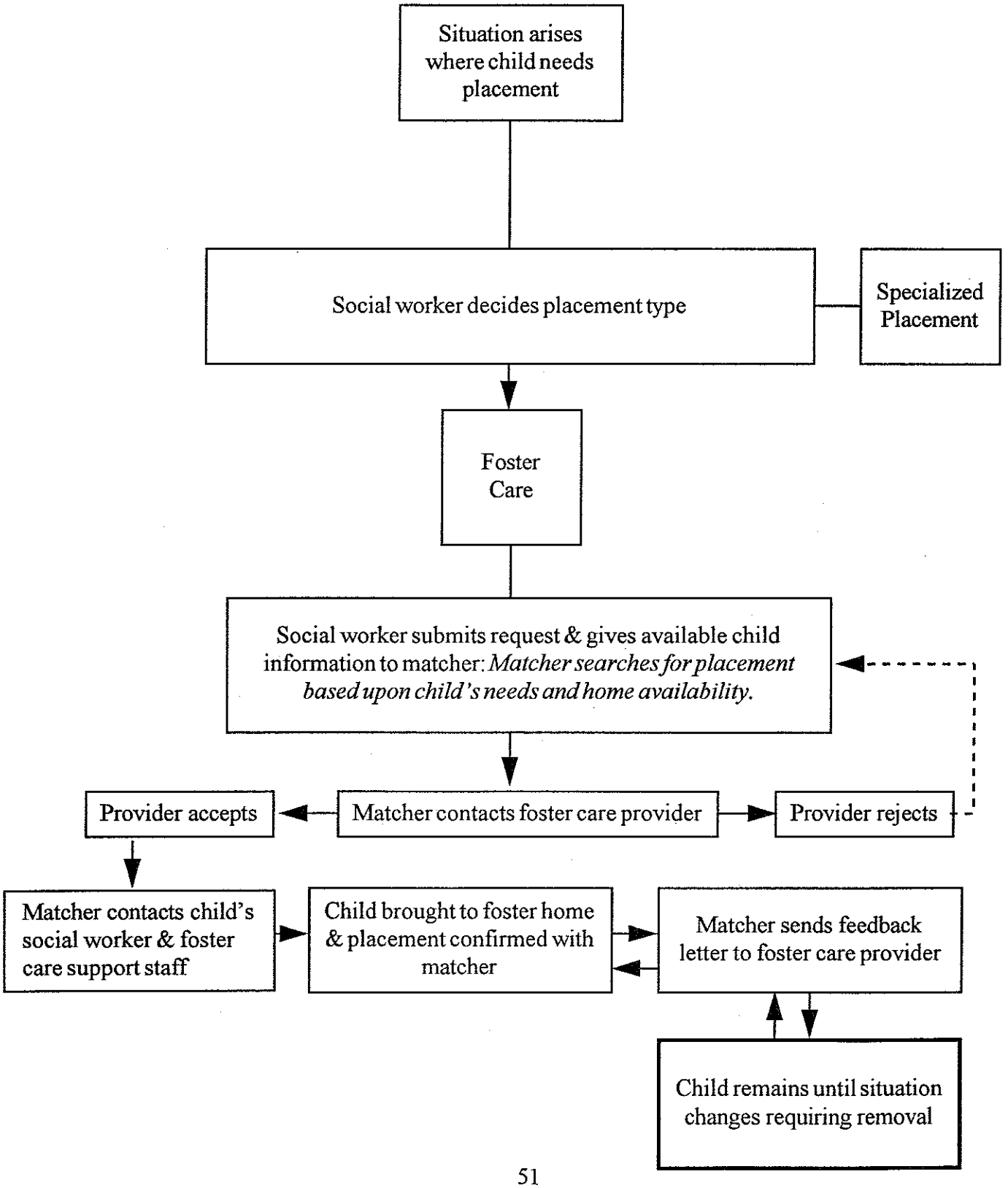
Source: DCF data.

Although the department established a training academy and developed policy guidelines related to matching, formalized training is not provided to matchers. All matchers interviewed by the committee indicated they receive on-the-job training. In general, the basic matching process is the same in each region. However, each matcher has developed his or her own methods of improving the system. Two regions have developed informal written procedures for the matching process.

Figure IV-4 illustrates the DCF placement process for children put in the department's care. As the flowchart shows, the process begins when a situation arises where a child needs placement. According to the department, this is usually an emergency situation. However, it may be a pre-planned removal of an active case. The social worker makes the initial determination whether a regular foster home is appropriate. If not, alternative out-of-home placement must be discussed. These alternatives may include, but are not limited to: CHOICE home; residential group home; Riverview; Long Lane; or the State Receiving Home.

If regular foster family care is appropriate, it is the responsibility of the social worker to submit a placement request form, with a supervisor's approval, to a matcher. Every matcher uses three tools for matching: 1) placement control cards; 2) DCF forms and policy; and 3) the subjective personal knowledge the matcher has gained through experience with the foster homes and children. The Child Placement Resource/Inquiry System (CPRIS) was initially designed for the placement system. In addition to basic demographic and licensing information, CPRIS was to provide information to facilitate selection of the most appropriate home for a child. However, the system did not perform to the level that it was intended. As a result, all matchers interviewed indicated they

Figure IV-4. Foster Care: Placement Process



rarely if ever used the CPRIS system to help with matching. In November 1995, the department decided to drop the CPRIS system completely. Automation will resume with the implementation of the Single Statewide Computer System (SSCS) which is currently in development and expected to be on line in 1996. The request form should provide the matcher with as much information as possible about the child and the circumstances of the placement. Upon receipt, the matcher reviews the request form to confirm the child is appropriate for regular foster care and determine if resources are available to meet the child's needs.

If the request is accepted, the matcher reviews the information to decide if there is enough information to select a home. If there is not enough information the matcher may attempt to contact the social worker to further discuss the child's placement needs. In emergency situations where contact cannot be easily made, the matcher will proceed to manually search placement control cards for all available and appropriate homes. The search is a process of elimination governed by the child's needs, resource availability, DCF matching policy, and the matcher's sense of the home's willingness and ability to handle the placement.

The department's matching policy requires that:

- a provider and child are of the same racial and cultural background and speaks the child's primary language. When this is not feasible, the child is placed in a home that has previously provided transracial/cultural care to children;

- reasonable efforts are to be made to place siblings in the same home unless special needs precludes placing them together. If the decision is between proximity to biological home and keeping the children together then preference shall be given to keeping the children together; and

- the maximum number of children who may reside in a foster family home is six including the provider's own children. With the exception of foster care siblings, a foster family home should not have more than three foster children, no more than two children under two years old, and no more than three children under six years old.

Any exceptions to the DCF matching criteria must be approved by the program supervisor and deemed to be temporary. The matcher must maintain a log of all temporary placements and an alternative placement must be found within 50 days. If necessary, the department may take steps to specially recruit a home for a child's placement.

Once the matcher has identified a home for the child, initial phone contact is made with the foster parent. The matcher provides as much information as possible about the child including special needs and the circumstances of placement. The foster parent has a right to accept or deny the placement of the child.

If the foster family home accepts the placement, the child's social worker and the foster home's FTSU worker are notified of the acceptance. At the time a child is placed in a foster home, the social worker must confirm the match and provide the foster family with information and documents necessary for the proper care and supervision for the child's specific needs. If it is an emergency placement, the social worker must provide the information within 24 hours or one working day from the time the child is placed.

Once placement has been made, the social worker must notify the matcher that the placement occurred. The matcher then sends the foster family home a letter requesting feedback on the placement. The letter, which indicates whether an issue or problem exists with the placement, is returned to a supervisor. Any issues or problems are resolved by the social worker or the support worker. The child remains in the home until a change of circumstances requires removal or new placement.

If the foster care provider requests removal of a child, the child's social worker must notify the matcher and the matcher must send the foster family a removal feedback letter. The matcher must attend any conference regarding the child's removal. If a placement is temporary, the matcher must inform the foster family of the progress regarding alternative placement.

Treatment. After a case has been opened, investigation completed, and initial placement decision made, the case is transferred to the Treatment Unit. According to the department policy manual, a conference must be held within 10 days of transfer to the treatment unit. The purpose of the conference is to discuss the problem which brought the case to the attention of the department and to assess the child and family in preparation for a treatment plan. However, in practice, an actual conference is not held but rather information from all the relevant parties (the parent[s], child [if appropriate], case worker, community agency [if necessary]) is collected by the social worker to develop the initial treatment plan.

Required by state and federal law, a treatment plan is the written working agreement between the child, family, provider and social worker. It describes and documents the child's or family's service needs as well as how each party agrees to address these needs. Within 90 days, additional information and progress are documented. At that time the initial treatment plan is reviewed and replaced with an ongoing treatment plan. The ongoing plan is reviewed every six months by the Quality Assurance Unit.

The treatment plan is guided by the principles of permanency planning which focus services on the most appropriate permanent goal for the child which may include: (1) reunification with the family; or (2) termination of parental rights with placement in adoption, long term foster care, or independent living.

According to department policy, reunification with the family should be the first goal. However, if this is not possible, one of the other alternatives will be considered. Table IV-5 lists the

goals for children who were in out-of-home placement for more than six consecutive months as of January 1, 1995.

Table IV-5. Goals for Children in Out-of-Home Placement		
GOAL	FREQUENCY	PERCENT OF TOTAL
Reunification	2,028	49%
Adoption	597	15%
Permanent Foster Care	343	8%
Independent Living	772	19%
Other	371	9%
Source: DCF Children in Placement Report: 1995		

Intervention Services. The primary objective of intervention services is to reduce the risk and likelihood of further abuse or neglect and to make the child's home physically and psychologically safe. The department attempts to achieve this by providing families with services and programs aimed at either keeping a child in its biological home **or** rehabilitating a family and preparing a child for reunification.

The first step is a diagnosis of the problems and selecting the service or program that addresses the need. There are few services which concurrently address all client problems, therefore, case management is crucial. The treatment plan lays out a written agreement between the parties including what problems need to be solved, what goals need to be met by each person, what services are needed to meet the goals, and the responsibility of each person in meeting those goals. The social worker is primarily responsible for monitoring the implementation of the treatment plan. The social worker monitors the plan by: reviewing required reports submitted by professionals; attending case conferences; and visiting and telephone contacts with the parties involved in the treatment plan. According to department policy, there must be weekly contacts with the child. The social worker also provides a weekly monitoring update to the treatment worker supervisor. The social worker is required to make all reasonable efforts to resolve any problem identified through monitoring.

Among the services and referrals offered to clients are:

- individual and family counseling;
- daycare services;
- emergency shelter;
- parent aid;
- psychological and psychiatric evaluation;
- referral to Department of Social Services;
- substance abuse programs;
- housing services;

- legal aid;
- medical services;
- self help groups (i.e., Alcohol Anonymous and Parents Anonymous); and
- youth services bureau.

These services can be provided by community providers, private residential facilities contracted by the department, or by DCF-operated institutions. Examples of community providers include child guidance clinics, extended day treatment programs, and therapeutic daycare. Other services are provided through a number of private residential facilities contracted by the department. In addition to contracted services, DCF also operates it own facilities. These include:

- **Riverview Hospital** (Middletown) - the state's only psychiatric hospital for children between the ages of 5-17. Children placed in this restrictive facility exhibit severe emotional disturbances and/or personality disorders creating risk to themselves or others;

- **High Meadows** (Hamden) - a residential treatment facility for adolescents (12 -17 years of age) who are severely emotionally disturbed but do not require an intensive restricted environment;

- **Long Lane** (Middletown) - a residential treatment institution for adjudicated delinquents (aged 11-16). The level of supervision ranges from maximum security units to open cottages; and

- **State Receiving Home** (Windsor) - the only state operated residential diagnostic center. It is frequently used as emergency placement by DCF regions lacking available placement resources. As a diagnostic center, the State Receiving Home conducts a complete diagnostic and treatment evaluation. This diagnostic process includes medical, psychiatric, psychological, psycho-social, educational, behavioral, and life skills assessments. These diagnostic findings are used to develop treatment plans and behavior management strategies designed to maximize the child's chances of returning home or placed in the most appropriate environment.

Administrative Case Review. According to state and federal law, the treatment plan must be administratively reviewed every six months. This administrative case review is conducted by the department's Quality Assurance Unit. The review is attended by a quality assurance reviewer, social worker, social worker supervisor, and any community provider necessary. In addition, the parent(s), child (if over 12), foster parent, and counsel are invited to attend. The purpose of the review is to detect weakness and obstacles in the plan.

The review examines the treatment plan, services provided, permanency goal, and child's placement. Specifically, it focuses on the plan implementation and progress in meeting the permanency goal as well as the continuing necessity and appropriateness of placement. At the conclusion of the review, the quality assurance reviewer makes written recommendations including reasons to maintain the current plan or to change it. This may include additional services or a change in the permanency goal. As stated previously, the first goal should be reunification with the family. However, if this is not possible, then the department may seek termination of parental rights resulting in adoption, long term foster care, or independent living. The commissioner may petition the court for the termination of parental rights to any child committed or voluntarily placed in her care. The superior court may grant the petition if it finds the termination is in the best interest of the child or if a parent has voluntarily consented to relinquish parental rights. However, termination of rights may be contested by a parent. When TPR is granted the birth parents no longer have any legal rights to the child. The child is then free to be adopted by another family.

Adoption. Within 10 days of termination of parental rights, children whose permanency goal is adoption must be registered and photo listed with the Connecticut Adoption Resource Exchange (CARE). The child is assigned to an adoption specialist who works to recruit potential adoptive families for the child. The listing is sent to over 250 agencies and adoptive parent groups throughout the country. For some children, a photo listing in the CARE book is not enough to find a permanent family. In those instances, the CARE worker and child's social worker may decide to photo list the child in other exchanges. Furthermore, specialized recruitment efforts may be conducted through Thursday's Child on WTNH (Channel 8), adoption parties, and the One Church/One Child program.

In developing the adoption plan, the adoption specialist meets with the child, child's worker and caregiver, reviews the case record, and prepares an adoption plan. The plan provides a description of the child including medical, psychological, educational, behavioral needs, and preferred placement such as family of similar racial, cultural and/or language background.

All potential adoptive homes (including foster family homes) must undergo an assessment and home study process which evaluates a family's readiness to adopt. Financial and medical subsidies are available to adoptive parents of special needs[5] children through state and federal funds. Adoptive parents must apply for subsidy payments annually at the discretion of the Adoption Subsidy Review Board.

Independent Living. The Independent Living program, designed for youths 15 years old or older, is based on a continuum model. The core program is Community Life Skills which provides basic independent living skills training. Its curriculum focuses on problem solving and self- reliance in the areas of employment, housing, money management, health, and transportation. Building upon the Community Life Skills program, the department also provides transitional living group homes and

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[5] Special needs is defined as: physical or mental disability; serious emotional maladjustment; a recognized high risk of physical or mental disability; over age 8 or racial or ethnic factors that present a barrier to adoption; a member of a sibling group that should stay together, and certified as a special needs child by DCF.

transitional apartment programs for youths who are ready for a less restrictive environment, but not yet ready for complete independence. Once successfully completing the above programs and achieving full independence, the department monitors the youth's progress through its Aftercare program offering supportive intervention and referral services when needed.

Case Management Analysis

The program review committee evaluated the implementation of DCF policies and procedures relating to foster care through an examination of case management practices and assessment of the placement process. The information was compiled from the DCF policy manuals, regulations, case files, and interviews with DCF staff and foster care providers.

The social worker, as the department's primary case manager, is responsible for supervising the needs of the children in the agency's care. Department staff are required to record in a timely fashion information regarding activities, observations, events, and decisions conducted in their work with children and families served by the department. All this information should be found in case records maintained in the regions.

The purpose of the documentation within the case record is to: provide a quality service to children and families; demonstrate that department mandates, policies, standards, and procedures have been met; and provide a narrative which can be used to make decisions regarding a child's protection and permanency plan. Two independent case reviews which were conducted to evaluate certain aspects of DCF case management are discussed below.

Case review. During the course of the study two independent case reviews were conducted using DCF case files. The first case audit, known as the 100% Case Review, was conducted by the court monitor's office. The purpose of this audit was to prepare and design a comprehensive review of a statistically valid number of DCF cases and to produce findings and recommendations. Among the issues to be reviewed were: the number of workers assigned to a case; whether the case had a current treatment plan; the last date a worker had a face to face contact with the child; and the number of times a child had been moved since the initial placement. The court monitor's office reviewed 82 cases using a treatment plan summary instrument developed by the department. The results discussed in this section regarding the court monitor's findings are program review's interpretation of preliminary outcomes of their data. The court monitor's office expects to complete a full analysis and report in early 1996.

As part of the Legislative Program Review and Investigations study, the committee conducted it own evaluation of two types of DCF files. The program review case audit included a random sample of 114 cases of children currently in placement as of October 23, 1995. In addition, the committee examined the files of the foster care homes in which the children were placed. The purpose of this review was twofold. First, the committee examined the condition and quality of the case record. Second, the committee checked adherence to certain DCF policy requirements.

Demographic profile of program review sample. The program review sample included 114 cases of children in foster care placement as of October 1995. Of these cases, 61 percent were males and 39 percent females. Forty eight percent of the children were white; 28 percent were black; 15 percent Hispanic; 9 percent biracial or of other ethnic categories. In terms of education, 70 percent of the children were enrolled in school; while 30 percent were under school age.

Forty percent of the cases had been opened for more than two years while 20 percent were opened for one to two years. Twenty-one percent were opened for less than a year but more than six months. Nineteen percent of these cases were opened for less than six months. Exactly 50 percent of program review sample were either actually reopened cases or cases in which the department had investigated a referral prior to the current opening of the case. Involuntary placements constituted 79 percent of the sample while 21 percent of the initial placements were voluntary.

Case file audit. The program review case audit focused on issues similar to the court monitor's audit. These include a review of documentation regarding treatment plans, placement history, medical passports, case assignments, social worker contact with the child, and administrative case reviews.

Treatment plans. The program review case audit found 96 percent of cases reviewed had a current treatment plan. The remaining 4 percent did not have a treatment plan because the case had only recently been opened. It is DCF policy that every child in foster care must have an assigned outcome or goal in their treatment plan. Permanency goals for children in foster care are: return home, placement with a relative or legal guardian, adoption, permanent foster care, or independent living. According to DCF policy, the first goal should be reunification with the family. However, if this is not possible, then the goals may be adoption, permanent foster care, or independent living. DCF policy states adoption should be the first plan for any child who cannot be returned to his or her own family.

The results of the program review case audit reflect this policy. The most common permanency goal in the sample was reunification (56 percent) followed by adoption (25 percent). This is consistent with the court monitor's results which found that reunification was the goal for 46 percent of the cases followed by adoption (22 percent). Permanent foster care accounted for 12 percent in the program review audit and 11 percent in the court monitor's sample.

Medical passport. The medical passport is a summary of a foster child's significant medical care and history. It provides a way to record a child's medical needs and the medical care a child has received while in foster care. According to DCF policy, each child in an out-of-home placement must have a medical passport issued and provided to the foster family at the time of placement or as soon after placement as possible.

It is the social worker's responsibility that every child placed in out-of-home care has a medical passport which has been completed, distributed, and used. The passport is kept in the possession of the foster parent. However, the social worker must check monthly with the provider

to ensure the required health examinations have been scheduled or have occurred, routine health care and dental care are ongoing; and the medical passport is continuously being used and updated. According to DCF policy, the social worker must take the medical passport to the regional office for review, place a copy in the child's case record, and then promptly return it to the foster parent.

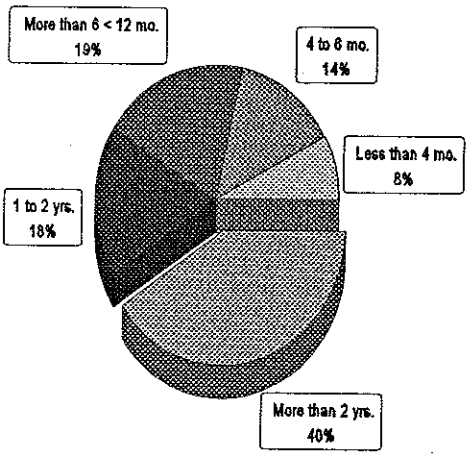
Program review searched case records to determine when the medical passports were issued and if copies were in the case records. Committee analysis revealed that in 61 percent of the cases a medical passport was issued on the same day the child was placed. Twenty percent were issued within 45 days and 18 percent were issued after more than 45 days after placement occurred. Seventy-eight percent of case records reviewed had a copy of the medical passport. The court monitor's review indicated that in 57 percent of the cases examined the medical passport had been reviewed in the last six months, while 42 percent had not. The committee's analysis of the medical passports had similar results.

Placement history. The committee and court monitor's reviewers examined placement forms filed in the child's record. As the court monitor's review found that placement forms were not consistently used or updated, the program review committee also verified the child's placement history against the department's vendor payment system.

The committee examined the length of time a case was open before initial placement occurred. The committee found in most instances (83 percent) the case were opened and the child placed on the same day. Seven percent were placed within two weeks of the case opening while the remaining 10 percent were placed more than two weeks after the case was opened.

Program review also examined the length of time a child was in placement (Figure IV-6). The committee found 8 percent had been in placement for less than 4 months, 14 percent for 4 to 6 months; 19 percent for more than 6 months but less than a year; 18 percent were in placement for 1 to 2 years; and 40 percent have been in placement for more than 2 years.

Figure IV-6. Length of Time in Placement

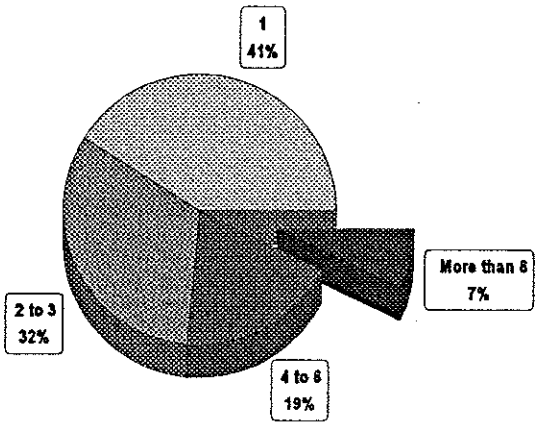


As Figure IV-7 illustrates, committee analysis found 41 percent of the children experienced only one placement. Thirty two percent had two to three placements. Nineteen percent had four to six placements, while the remaining seven percent had more than six. The seven percent that had more than six placements were cases in which the child had been in placement for three or more years. The court monitor's

data based solely on placement forms revealed 30 percent had been moved once since initial placement. Forty-three percent were moved two to three times, 16 percent were placed four to six times. Eleven percent were moved more than six times.

DCF policy addresses the issue of multiple placements by requiring a case conference for any child experiencing two or more foster home disruptions within an 18-month period for reasons related to the child's behavior or condition. The disruption conference must be attended by the child's worker, the worker's supervisor, any appropriate community service provider, and any other expert needed to plan for the child. The conference is to determine whether or not it is in the child's best interest to place him or her in another foster home or whether a different type of placement setting may be more appropriate. All consultations between the child's worker, and FTSU workers are to be documented on Placement Disruption Conference forms which must be filed in the child's uniform case record.

Figure IV-7. Number of Placements



The program review committee did not find a placement disruption form in any of the cases reviewed. This is not to imply that a placement disruption conference did not actually occur, but rather that the policy mandated form documenting what happened at the conference was not found in the case file.

Administrative case review. DCF policy requires every treatment plan to be administratively reviewed at least every six months. The review examines the treatment plan, services provided, permanency goal, and child's placement. Specifically, the review focuses on implementation of the treatment plan and progress in meeting the permanency goal as well as the continuing necessity and appropriateness of placement.

Program review found all but 11 cases of its modified sample had documentation that an administrative case review was completed in the required time frame. The 11 cases were overdue by one to two months.

Social worker contacts. During the first 30 days after a case is opened, the social worker is required to see and speak to the child on a weekly basis. After the first 30 days, weekly contacts

continue to occur but telephone contacts may alternate with face-to-face visits. According to DCF policy, social workers must maintain case activity notes documenting in narrative form all contacts, telephone conversations, and written communication with the child, birth parents, foster parents, service providers, attorneys, and anyone else connected with the case. The narrative must include the date and time of all contacts, persons with whom the contact occurred, and method of contact.

The committee focused on case activity narratives written between June 1, 1995, and November 1, 1995. The narratives were read to determine the number of face-to-face contacts and telephone conversations social workers documented with the *child* during this time period. In cases where the child was an infant or toddler, program review counted social worker contacts with the foster care provider. The results of this analysis are illustrated in Table IV-8. As the table illustrates, cases opened prior to June 1, 1995, should have had at a minimum 22 social worker contacts. The analysis found that only four cases (4 percent) actually had more than 20 contacts. In addition, five cases (5 percent) had no documented contact. The table also demonstrates that documentation of the required number of contacts were not found in the 21 cases opened after June 1, 1995. Only four cases were found to have more than the expected number of contacts. These findings seem to substantiate the foster families comments which are discussed in Chapter V.

Table IV-8. Frequency of Social Worker Contacts with Foster Children.

	Actual	0	1-2	3-4	5-8	9-12	13-16	17-20	21-24	25+	TOTAL
Case Open	Required										
<June	22	5	8	15	22	21	10	7	1	3	92
June	22-18		1	1	4	3	1				10
July	18-14	1	1	1	3						6
Aug.	14-10		1	1							2
Sept.	10-6		3					1			4
TOTAL											114

Shaded areas indicate the possible range of required contacts for cases opened during the months listed.
Source: LPRIC case audit.

Case assignments. Another issue examined by both program review and the court monitor was social worker turnover on a case as this has the potential to greatly effect how a case is managed. The court monitor's review sought to ascertain how many workers had been assigned to the case since the date of initial placement. The court monitor's results show 17 percent of the cases reviewed had one worker assigned. Twenty-nine percent had two workers, 15 percent had three and another 15 percent had four. Twenty four percent had five or more workers. It is important to note that the forms the court monitor audit used to calculate the assignments are not consistently filed in the case record and sometimes duplicate copies of the form were found.

The program review analysis yielded somewhat different results. As Table IV-9 shows, 29 percent of the cases had one worker assigned. Twenty-seven percent had two workers, while 13 and 15 percent had three to four workers assigned, respectively. Sixteen percent had five or more workers assigned. The committee also compared the number of workers to the length of time the case had been opened. This analysis shows the cases that had five or more workers were open two or more years.

Table IV-9. Social Worker Case Assignments/Turnover.

Number of Workers	1	2	3	4	5+
LPRIC	29%	27%	13%	15%	16%
Court	17%	29%	15%	15%	24%

Source: LPRIC and Court Monitor case audits.

Services to prevent out-of-home placement. According to DCF policy, treatment workers must make every effort to offer and provide services to prevent out-of-home placement and facilitate reunification of children in out-of-home care with their families. All services offered must be documented in the child's uniform case record. If DCF is not able provide or contract for a service, the reasons are documented and also filed in child's uniform case record. This documentation records the parent's willingness to accept services which may then be considered in determining the degree of risk to a child if left in his or her own home. While the court monitor's audit attempted to review this documentation, the reviewers discovered that the DCF form used for documentation was rarely included in the case record. Thus, no useful information could be compiled.

It should be noted that these findings reflect what was found or not found in the case record. This is not to say that mandated steps were not taken or information and documentation does not exists elsewhere. However, the absence of mandated information and documentation in the case record is a violation of the DCF policy manual.

The case record serves several purposes in case management. First, it is used as a reference document providing current and historical information on the client. Second, it can demonstrate the department's progress or lack of progress in working with a family. As such, the case record may be used as a decision making tool for the agency and the courts.

In order to function effectively as a case management tool, the case record must contain complete information and in a timely manner record all activities, observations, events, and decisions made while working with DCF clients. Overall, the program review committee found significant variation in quality of DCF files. Information was piecemeal and documentation was inconsistent.

In general, program review found the case records were unwieldy and cumbersome. This is due in part to the fact a child's individual case record is maintained as part of the family's file. Narratives included in the case records were sometimes typed but more frequently were hand written in abbreviated fashion. Generally, the narratives were prepared, as required, on DCF case activity forms. Occasionally, they were written on miscellaneous pieces of paper. Both the program review committee and the court monitor reviews identified several areas in the case records where mandated forms were used inconsistently or were not reliable sources of information.

In terms of case planning, the program review committee found DCF met its mandates to develop treatment plans, establish permanency goals, and administratively review cases. However, committee analysis suggests adherence to DCF policies related to the medical passport and social worker contacts were problematic. These policies are established to assess and document whether or not a child is receiving proper care and supervision. They also allow the department to check if the provider is having difficulties in caring for the child or meeting the expectations of the treatment plan. Therefore, these practices must be corrected.

When asked about case management policies and procedures, social workers interviewed by program review responded that numerous and redundant forms are an impediment to effective casework. Many felt that paperwork and administrative duties often kept them from spending sufficient time with clients. High caseloads also created time constraints. Social workers are the principal case managers and thus have the difficult task of fulfilling multiple responsibilities while complying with numerous policies and procedures. Nevertheless, thorough record keeping is essential to case management. When it is incomplete, outdated, or lacks critical information, the reliability of the record and agency objectives are compromised. More importantly, the progress, health, welfare, and safety of the child is compromised.

Proper maintenance of the case record will assist the primary worker to understand the client's needs and assess how those needs are being met. Accurate and complete information is also critical to ensure that: 1) all other workers assigned know what is happening in the case; 2) when, as the committee's sample indicated, there is staff turnover, new workers will have access to critical information needed for continuity of services; and 3) the agency has proper documentation for legal and other proceedings and evaluating of the effectiveness of its services.

Matching

Among the issues the committee examined related to matching children and foster families were: inappropriate requests; inadequate information; communication between DCF and providers; and removals from foster care homes.

Inappropriate requests. Matchers interviewed during the committee's review all noted that at times they receive requests that are inappropriate for regular foster care. Under the current system, matchers only handle requests for placement in regular foster care homes. If the matcher feels the child is inappropriate for regular foster care, he or she will notify his or her supervisor who will

discuss alternative placement options with the matcher and social worker. Social workers needing specialized placements must locate these themselves without assistance from the matcher. Specialized placements include group homes, private- and DCF-operated residentail facilities, and hospitals.

The program review committee finds this split in placement responsibility creates additional steps in a process where time is of the essence and adds more responsibilities to social workers who are already overburdened. If the child can not be placed in a regular foster home, social workers are forced to search out alternatives. According to social workers interviewed, these alternatives are limited and do not take all children. Most specialized placements have specific intake criteria and do not take emergency placements. Furthermore, because the children are in the state's custody, the department has no choice but to find a placement. Many times this "no choice" placement is regular foster care even if it is not the most appropriate type of placement. Therefore, placing children in regular foster care is sometimes seen as a simpler, less time consuming solution to assuring the child's safety. Once the child is in foster care and his or her safety assured, busy social workers can proceed with other activities.

Inadequate information on the child. All matchers interviewed indicated they rely heavily on the placement request form to select an appropriate foster home. According to the matchers, social workers must fill out the request form as completely as possible in order to obtain the best possible match. When completed, the form provides essential information regarding the child's situation and needs to the matcher. All workers acknowledged that complete information may not always be available to the agency in emergency cases. However, there seemed to be an indication that social workers either did not realize the value or use of the request form or were so busy dealing with other issues that the request form is viewed simply as additional paperwork. As a result, matchers stated that request forms usually contained nominal information.

The program review committee finds this practice conflicts with the principles of locating the most appropriate placement. Furthermore, it undermines the department's relationship with the provider. If a foster family is given insufficient information about a child prior to placement, the family cannot make an informed decision of whether or not to accept the child into placement. Many foster families interviewed feared they will be considered uncooperative or that the agency will not consider them for future placements if they choose not to accept a child into their home. The risk of disruption increases when foster families feel pressure from the agency to accept a child even when they have doubts about the placement. More careful matching of foster home and child is necessary to prevent frequent and multiple placements in different foster homes.

Sharing information with foster family. According to all DCF workers interviewed, all *available* information is provided to the foster family. The department's policy states that information and documentation not available at placement will be provided to foster families as soon as possible. In fact, the DCF Foster Parent Handbook tells the foster family they can expect to receive a phone call from the child's social worker the next working day after placement.

Interviews with foster parents suggest this does not always happen. Most foster parents stated that, especially during emergency placement, they are not informed of the social worker's name for several days. Many of the foster parents interviewed indicated children are usually just dropped off with little or no information provided. When information is not shared, providers may feel the agency "didn't tell us everything" or "this is far worse than we expected". This creates anxiety and resentment on the part of providers and a lack of trust of agency staff. Furthermore, it also makes caring for the child difficult. It is unreasonable to expect caregivers to provide proper care and supervision without providing them adequate information or necessary documents.

Removals. When asked to identify weaknesses in the current matching process, all matchers mentioned notification of removals. When a child is removed from a foster home, it is the social worker's responsibility to notify the matcher a vacancy is available. Matchers interviewed stated many times vacancies occured of which they are not aware for days or even weeks. Several matchers reported they became aware of vacancies when they called foster care providers about another placement. Others learned beds were available because foster parents called to complain they had openings in their homes and had not heard from the matcher.

The program review committee finds this lack of communication sets off a chain reaction of problems. Without prompt notification, matchers cannot update a basic matching tool: the placement control cards. When the control cards are inaccurate or incomplete, matchers are making placement decisions without knowing what options actually exist. The result is matchers may unnecessarily overload homes or resort to the questionable practice of filling beds in homes that have not fully completed the licensing process.

This practice also effects foster parents who have vacancies. Because matchers do not realize some providers have openings, they may not call a home to fill a placement. Foster parents who have vacancies and no placements feel that their services are not valued or they have done something for which they are being punished. This issue was mentioned in several foster parent interviews. Finally, without the ability to accurately track and use vacancies, the department can not optimize its resources nor accurately project need.

Case review of provider files. In addition to information obtained through interviews, the committee also examined provider files. The review focused on evidence of communication and correspondence between the department and providers regarding placements. The audit revealed that information communicated through policy mandated forms are rarely if ever used.

Upon acknowledgment of placement, the matcher must send the foster family a Placement Feedback Letter. This form letter inquires how the placement proceeded and if the provider received all the necessary documents and information to provide care for the child. The program review committee case file audit showed 86 percent of files examined did not have this form.

The matcher is also required to send another form letter to the foster parent when a child is removed. This letter inquires about the child's stay and removal. In particular, the letter asks how

often the social worker visited the child, if the foster parent was told about court action, and if the foster parents feel they were able to handle this type of child. The committee file review showed 89 percent did not have this form, and interviews with foster parents suggest many had never seen either form. According to DCF policy, feedback letters are "to be utilized for improving practice regionally and statewide." While it's unclear if letters are never sent or returned, program review finds that this system of communication is not effective and not meeting its intended purpose.

Removal notification serves another important function. When social workers notify a matcher of removal, they are asked to evaluate the foster home in terms of overall care, the ability to work with biological parents, ability to work with the agency, and whether the agency should use the home again. This information must be updated and documented in the provider file to facilitate placement and relicensing decisions. The file audit revealed that 82 percent had no evidence of social worker evaluation.

Overall, the program review committee finds the Department of Children and Families has developed comprehensive policy and procedures relating to foster care. However, the committee through its case review and interviews identified several deficiencies in policy implementation due to a lack of consistent and updated record keeping and poor communication and information sharing among its own staff and providers. Specifically, program review found that splitting the responsibility for locating out-of-home placement between the matcher and social worker is impractical.

The committee also concluded that matching a child with the appropriate foster home and supporting the foster parent and the child through placement requires clear communication and a coordinated team effort. Information relating to the child's needs, behaviors, and anticipated problems should be carefully assessed *prior* to choosing the placement. Limited options and unknown resources create an environment where placements are chosen on a single criteria: available bed space. As a result, many children may be placed with families who may not be best suited to care for them. This practice greatly increases the risk of placement disruption and multiple placements for a child.

The program review committee found the decision regarding *where a child should be placed* is as important as the decision *to place*. Improper matching activities and an absence of comprehensive case planning can substantially increase the likelihood of placement disruption and potential foster care drift. Placement decisions must be based upon sound, factual information about the child. Care givers must be provided with complete and accurate information about the child. Case workers must adhere to DCF policies and procedures and ensure through observation and direct inquiry that all the child's basic needs are met and documented. The success of placement is enhanced if all participants are properly prepared and informed.

Therefore, the Legislative Program Review and Investigations Committee recommends the Department of Children and Families develop and implement the use of a child placement portfolio. At a minimum, the child placement portfolio should contain:

Current information on the child including:

- **accurate name, birth date, primary language, and religion;**
- **names of parents and siblings or significant others (grandparents, etc.);**
- **copies of necessary documentation such as birth certificate, social security number, and medical insurance card;**
- **reason for current placement and legal status;**
- **current permanency goal including expected length of stay, visitation plan, and anticipated date of next administrative case review;**
- **updated medical passport;**
- **name and telephone number of :**
  - assigned social worker and supervisor;
  - child's attorney;
  - educational surrogate (if applicable);
- **a recent photograph of the child;**

Historical/Background information:

- **summary of educational needs including a listing of schools attended and special education services required;**
- **placement history including a listing of all placements and dates;**
- **profile of child including characteristics, special behaviors or fears, likes and dislikes (food, clothing, toys, etc...);**
- **summary of social workers assigned to the case;**

Administrative information:

- **telephone listing of pertinent regional and central office staff;**
- **summary of the rights and responsibilities of foster parents, foster child, birth family, and DCF; and**
- **description of the foster parent association including contact person, hotline, support group meeting locations and times.**

The child placement portfolio shall be part of the uniform case file of each child involved in an open DCF protective services case, and a copy provided to each foster care provider caring for children placed in the foster care system.

The placement portfolio should be a summary of information essential for the proper care of a child. It's purpose is to centralize basic components of the child's case record for easy assessment. The program review committee believes implementation of a placement portfolio would address several issues. It would serve as a quick reference guide to a child's case for all parties including workers who need to familiarize themselves with the cases due to case transfers, social worker vacations, after hour emergencies, or any other reason relating to unavailability of the assigned

worker. It also provides case workers with a basic checklist to aid them during the placement process. As a case management tool, it provides the social worker with a record keeping instrument to log and update pertinent information on the child in a consistent and uniform format.

The program review committee believes the placement portfolio should be prepared as soon as a child becomes known to the department. Based on the program review case review, most placements seem to occur on the same day a case is opened and many are active cases before an initial placement is made. In addition, a significant number appear to be reopened cases or cases in which the department has had some previous intervention or contact. During the initial intake phase, the department investigates and collects information from various sources which can be incorporated into the portfolio. By treating all opened cases as having the ***potential*** of out-of-home placement, the department can plan and prepare for the possibility of removal and smooth the transition when it happens.

The portfolio should be kept current by the assigned social worker, and used to make social worker contacts with the child and foster family more productive and meaningful while providing the foster home with the necessary information to care for the child. The portfolio should be reviewed at the required weekly supervisory conference. It should serve as an agenda for these meetings and ensure that decisions and progress are recorded and evaluated.

Development and implementation of a child placement portfolio, together with the previous recommendation consolidating the foster care functions into one unit, will streamline and reinforce the department's management of out-of-home care.

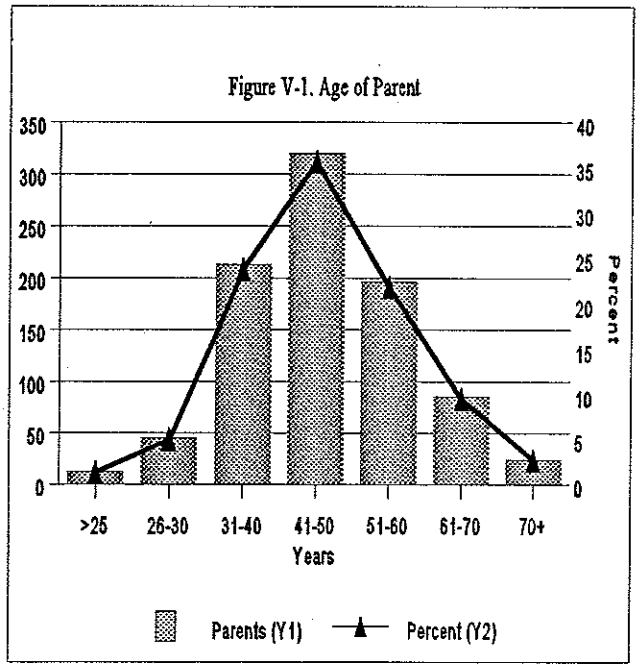
CHAPTER V

THE DCF FOSTER PARENT

The department has the overall responsibility for the placement and supervision of the children placed in foster care. However, DCF delegates most of the day-to-day caring for foster children to licensed foster parents. The department relies almost exclusively on approximately 2,000 licensed providers to care for more than 3,000 children currently placed in foster family homes.

To define the foster parents' role, the program review committee reviewed data and information from a variety of sources, including the department' policy manual, foster parent handbook, and foster care training materials. The department's foster care vendor payment data were analyzed as well as demographic information self-reported by a randomly selected group of 42 foster parents. That same group of foster parents participated in an extensive interview process. The information from the interviews was analyzed to identify trends in foster care and foster parents' perspectives on the DCF system. It was also used to compile six foster parent profiles presented in Appendix B.

The Foster Parent



Demographics. The analysis of DCF vendor payment data for the foster care system, represents a snapshot in time and provides an overview of licensed foster parent demographics. The department collected information on 1,990 primary care givers in licensed foster homes as of October 1995.

Almost all (9 percent) of the 1,990 foster parents were female. The ethnicity of the foster families was 50 percent white, 35 percent black, and 15 percent Hispanic. Six out of 10 were single while 36 percent were married and 4 percent divorced.

Figure V-1 shows the age of licensed foster parents ranging from 21 to 81 years, with the median at 47 years. As shown, 36 percent are between the ages of 41 and 50 years. Foster parents between the ages of 31 and 40 years represent 24 percent and 22 percent are between 51 and 60 years. A notable percentage (13 percent) of the foster parents are over the age of 60.

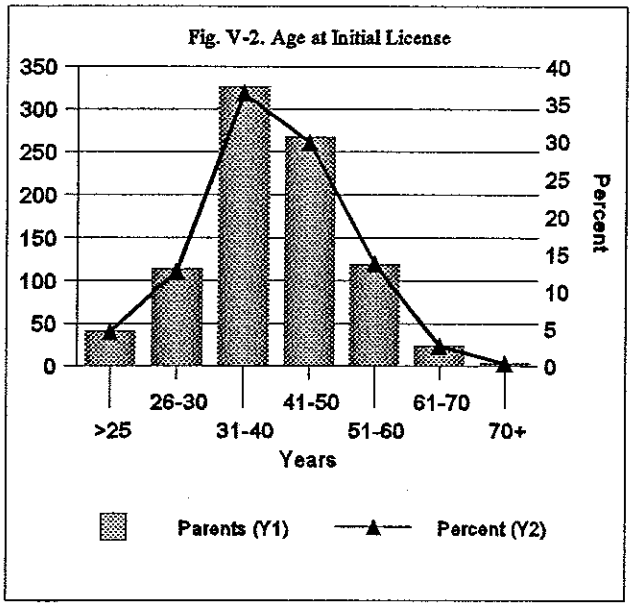
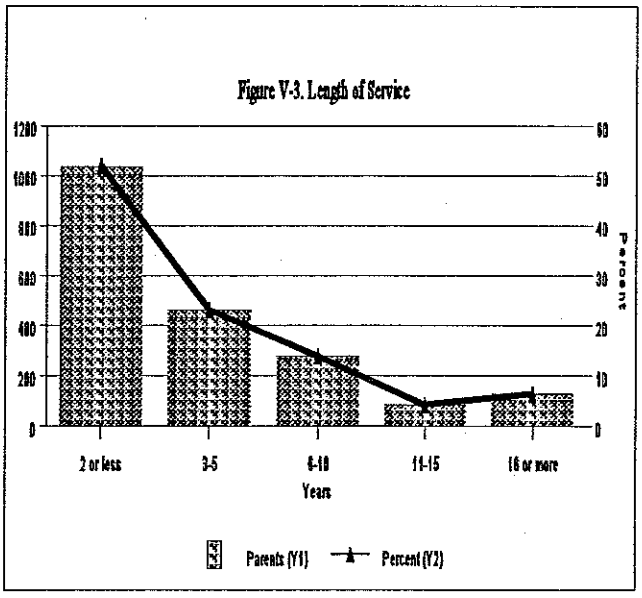


Figure V-2 represents the age of the foster parents at initial licensure by the Department of Children and Families. Two-thirds were licensed when they were between the ages of 31 and 50 years. The median age at initial licensure is 40, with the ages ranging from 21 to 78 years.

The median time period foster parents retain a license is only 2.7 years. The range in the length of service for licensed foster parents is from less than 1 year to 38 years. Figure V-3 illustrates the number of years foster parents retain a DCF license. Over half (52 percent) provide foster care for two years or less. The department's retention rate drops off significantly after the two-year mark with 23 percent licensed for 3 to 5 years, 14 percent for 6 to 10 years, and only 10 percent for 11 years or more.

The licensing data were also analyzed by bed capacity, and an almost equal number of homes were in each category of one to three beds. Thirty-seven percent of the homes were licensed for one bed, 33 percent for two beds, and 29 percent for three beds. Only 1 percent of the homes were licensed for four or five beds.



The program review committee conducted extensive interviews of 42 foster parents randomly selected from the DCF list of licensed providers. As part of the interview process, the participants provided demographic information. The information collected was self-reported and is unavailable from DCF or any other source. Because of the sample size (only 35 of the 42 foster parents responded), the demographic information collected is not representative of all licensed foster parents. However, it is the most descriptive information on specific characteristics available.

Almost two-thirds (66 percent) of the responding foster parents completed their high school education. The highest educational

level completed by 14 percent was grade school, and 20 percent reported earning college or advanced degrees.

The foster parents were also asked to report their annual family income. It is unclear if all foster parents reported DCF reimbursements for foster care as part of their annual income. Four out of 10 respondents (42 percent) earned between $35,000 and $49,999. Table V-4 shows the breakdown of income levels.

Table V-4. Foster Family Annual Household Income*.

Under $10,000**	$10,000-$14,999	$15,000-$24,999	$25,000-$34,999	$35,000-$49,999	$50,000-$74,999	$75,000+
6%	1%	15%	9%	42%	18%	9%

* It is unclear if foster parents reported DCF foster care reimbursements as part of annual family income.
** Five percent reported earning less than $5,000 per year.
Source: LPRIC foster parent demographic data.

Rights and responsibilities. The Department of Children and Families relies on a team approach to meet the needs of foster children. By policy, the team consists of the child's treatment social worker, the foster family's support social worker, the foster parent(s), the birth parent(s), and other service providers, such as doctors, teachers, and therapists. It is important to note that each party has certain basic rights and responsibilities prescribed through statute or DCF policy which may or may not be affected by the foster child's legal status. The following describes the rights and responsibilities explained by the department to the foster parent during the assessment process and post-licensing training. A complete overview of all rights and responsibilities of the foster child, foster parent, birth parent, and DCF is contained in Appendix C.

Foster child. A foster child has a right to visitation with parents and significant others (grandparents, siblings, etc.), unless restricted by court order. If capable, a child has a right to participate in all plans and decisionmaking regarding him or her. A child has a right to confidentiality regarding information about him or herself and his or her family. Finally, a child has a statutory right to independent legal representation.

Birth family. A birth family has a right to confidentiality. The parent(s) has the right to participate in treatment planning for their child; a right to visitation except if restricted by court order; and the right to know his or her child's progress and development. A parent also has the right to know of legal action taken on behalf of their child.

Foster family. A foster parent has a right to accept or reject a child for placement in their home. Once accepted, a foster care provider has a right to receive information regarding children placed in their home which is necessary to provide proper care and supervision. Foster parents have

a right to be notified of any legal action regarding any child placed in their home. Foster parents may deny entry to their home to anyone except a DCF worker. A foster parent may raise their own children in any manner they see fit as long as they do not conflict with DCF regulations or policy. A foster parent has the right to be included in planning meetings regarding foster children. Finally, a foster parent has a right to be informed of children being removed from their home, investigations of allegations against them, and revocation of their license.

A provider must respect a foster child's religion, culture, and racial heritage. A foster family must notify the agency of major changes in their household such as address, marriage, divorce, or illness. A provider may not use an alternative care giver unless approved by the department. A foster care provider must participate in any court proceedings concerning the child as requested.

Foster Parent Interview

Forty-two DCF foster mothers, chosen at random, voluntarily participated in the program review committee's structured interview process. Participants were asked, during private interviews, to respond to a series of questions on such topics as: their decision to provide foster care; training and preparation offered by DCF to foster parents; support services for foster parents; their relationships with foster children placed in their homes; and financial concerns in providing foster care. Completed interviews were tape recorded, transcribed, and responses were coded for analysis and review.

The foster mothers' responses were analyzed for trends and consensus. In reviewing the information gathered during the interview process, the program review committee focused on: (1) foster parents as part of the DCF team; (2) contact and working relationship between foster parents and DCF social workers; (3) information regarding foster children provided to foster parents; and (4) the foster parents' view on their role in the DCF foster care system.

The foster mothers interviewed represented a range of experience, backgrounds, age groups, and perspectives on foster care. From these interviews, the program review committee was able to obtain a first-hand look at what situations foster parents face each day, to learn why and how they provide foster care, and what keeps them in the system.

DCF team. When foster parents were interviewed about their participation in administrative review teams and their sense of team membership, most parents stated that although they were informed by letter of the meetings, they rarely attended. This was largely due to three factors: lack of alternative child care arrangements or babysitting; inconvenient meeting times; and foster parents' sense that their contributions were not valued.

The foster mothers often expressed that finding and paying for child care presented a hardship that prevented them from attending team meetings. This was especially true if the children in a foster mother's care had special needs or required specialized care and thus could not be left with "just any babysitter." In these situations, foster parents often took turns caring for a child while one parent

went to either an administrative review team or a support group meeting. However, if the reviews were scheduled during the day, or during a time when one parent was at work, this resource was not available. Foster mothers in particular, then opted simply not to attend.

Often the costs of hiring specialized help or even the cost of hiring a babysitter became prohibitive, since administrative reviews were not the only meetings requiring a foster mother's participation. Faced with many such expenses, foster mothers selected the meetings where they felt their input was most critical.

Finally, foster mothers often did not attend administrative case reviews because many did not feel their opinion was valued. While not hesitant to tell DCF staff their observations of a child's behavior and their opinions of what a child needed (e.g., enrollment in a Birth to Three program, or increased or decreased visits with biological parents), most mothers felt the information and expertise they could provide would not be used by the department in formulating a plan for the child. Such views were expressed by the following quotes:

> "In most cases, workers will listen to what you have to say, if they're looking for your input" or "They [DCF] listen to you... but whether they do anything about it, I don't know".

Generally, foster mothers did not see themselves as team members. They believed their role as a parent made them uniquely qualified to provide the department with information about the child, but the department was not interested in their suggestions. One mother stated:

> I had this little boy for two years, so who would know more about [him] than me? I thought more things should have went in [the case record] about him. I thought he should have been put in a program. I would tell her [DCF social worker] this and none of that was done and that bothers me.

Working relationship. Some interviewed foster parents were very quick to talk about positive working relationships they had established with individual DCF social workers. Most foster parents, however, pointed to serious problems in their relationships and were clear about how their jobs as foster parents were hindered.

Almost all of the interviewed foster parents complained it was difficult to reach social workers by telephone and calls were not always returned. Many foster parents stated that workers "never" came to visit children in their care with some stating they never met the child's social worker. Several foster mothers did not know the children in their care had social workers and simply communicated with DCF transportation aides.

Foster parents often complained that social workers were transferred within DCF so frequently that it was difficult, if not impossible, to know who the child's worker was at a given time. This, according to foster mothers, affected the formulation and implementation of a child's treatment

plan and overall case continuity. Many foster parents reported that case transportation aides often "dropped" children off at a foster home and there was little if any follow-up contact from a social worker. Departmental policy requires a visit or telephone contact with a foster parent the day after a placement is made to the home and weekly contact thereafter.

When parents reported that they had contact with social workers, they stated visits to the foster home often took place at the social worker's convenience. Foster parents were not given adequate notice of an impending visit and appointments were rarely kept on time. Foster parents also reported it was difficult if their foster children had different social workers. One family who fostered four children had four different social workers calling or visiting the children and the foster mother. Foster parents also complained that social workers seemed to have little time to consider the child's needs or to talk with foster parents about how a child was doing in care.

One mother explained she had one day off from work each week and, after waiting for two hours for the social worker to arrive, she went to run errands. She had not seen nor heard from the social worker in the several months prior to or after the scheduled visit. Many mothers stated social workers often called foster parents on the telephone instead of coming to the home to see the child. Foster mothers were concerned how social workers could formulate adequate treatment plans for children with whom they had no contact.

One foster mother felt the foster child placed with her, a relative whom she had known since birth, had an attention disorder that should be evaluated and perhaps the child should be placed on medication. The school agreed with the foster mother and felt the child would benefit from medication. The foster mother was told by the social worker, who visited the child less than once per month, that her supervisor "did not believe in medication" and, therefore, the child would not be evaluated nor medicated. The foster mother felt this decision was arbitrary since the supervisor never had contact with the child.

Many foster mothers reported that in response to infrequent visits and lack of support they developed strategies to deal with their foster children without the support or guidance of DCF social workers. In most cases this proved effective, but there were some things requiring social worker contact, such as permission to take a child out of state, permission for certain medical or psychological treatments, decisions about a child's education, or even whether or not a child could get a hair cut. Foster mothers primarily expressed their concern about the lack of social worker contact in terms of the lack of services foster children were receiving.

Several foster parents expressed the feeling they were being "punished" by DCF or expressed the fear that they might be "punished" (by having a child removed, by having services withdrawn, by having their license revoked, or by having no children placed with them) if they challenged or objected to any DCF practices or policies with regard to foster children. Several foster mothers stated DCF had not placed any children with them for several months following a disagreement with an agency social worker.

Foster child information. With few exceptions, the foster mothers interviewed felt that the Department of Children and Families provided them with insufficient information about a foster child either on initial placement or through follow-up contacts. Foster parents often received a child not knowing why a child had been removed from his or her home; what the child had experienced either emotionally or physically; or what physical condition the child was in at the present time. Foster mothers reported they seldom, if ever, had adequate information about a child's medical, emotional, or psychological history. This included not knowing what medication the child was currently taking, what allergies a child might have, or, if the child was an infant, what formula the child was given. Foster parents were seldom provided information about the child's educational needs or history.

Many foster parents reported the only information they received about a child was his or her name. Even this information, especially the child's surname, was not always correct. Many parents did not know the child's correct birth date, who or where the child's parents were, if the child had previously been in care, or how long the child was currently going to be placed. Foster parents generally attributed the lack of information to the social worker's ignorance of the facts. However, most foster parents also experienced having information intentionally withheld from them because it was "confidential". Several foster mothers raised the question, "if they trust me with the child, how come they don't trust me with information about the child?" Other foster parents stated that social workers simply did not know the importance of certain information to a care taker. This reflected on, according to foster parents, the social workers' conception of fostering as "just a job". One foster parent stated: "They don't think it's important because... they don't have that experience [parenting]. You know, it's just a job I'm doing. It's one less kid [they] have to worry about."

The lack of information impeded the care foster parents provided and sometimes created serious problems for the foster family and child. In several cases, children had a preexisting, serious medical conditions for such problems as asthma, a seizure disorder, depression, or hyperactivity and were taking medication. The foster mothers had no information about these conditions nor did they have medication. In all cases, not having access to adequate information had the potential to seriously compromise the child's physical health and to create a liability issue for the foster parents. Foster mothers reported that while children sometimes have a medical passport, the form is seldom filled out past a child's name. One mother showed program review staff the empty passport and asked what she should do with it. Many mothers said they would take the child to his or her regular physician, if they only knew who that was. Further, without proper medical information (such as an immunization history), foster parents had a very difficult time enrolling a child in school.

The lack of information about why a child was being placed and what his or her emotional history and needs were also had serious ramifications. Many foster parents reported not knowing that the child placed with them had been sexually abused. One foster mother reported she did not know that an older child, a boy, had been sexually abused and had a history of acting out sexually. This foster mother had two young girls in her home. She obtained the information only by speaking with the child's former foster mother. She stated:

> She [the former foster mother] told me a few things. She called me up and told me to watch him, he molested several little children. I didn't know this. I have two little girls in the house. I don't understand why the state didn't tell me this. You know, fortunately, she [former foster mother] was a great lady and told me these things so that I could be aware of it and set up a system where I could watch him more carefully.

Another foster mother only learned her foster son had been sexually abused when she called the agency and asked. The foster mother said, had she known that, she would have handled his care differently by having her husband assume a greater role in his physical care.

The only information another foster mother had about a recent placement of two children was their names and birthdates. She took the children for a walk in the park and was immediately approached by a relative, who recognized the children. The relative began to scream that the children had been unfairly taken away from the mother. The foster mother, frightened that the woman may try to take the children, quickly left. She was later told by a social worker that the parents and several relatives lived in the same town and should be considered dangerous to her and the children.

One foster mother stated: "If they're waking up screaming in the middle of the night, you need to know what it's about." Foster parents explained they had little follow-up information about the child's treatment plan. They did not know how long a child would remain in foster care, whether the goal was family reunification or termination of parental rights, or whether a child's plan was for short- or long-term care. Foster parents often felt they had inadequate time to prepare themselves or the child for a change in residence when a child was returned home or released for adoption.

Many foster parents reported children were left in their homes for years with no plan for permanence. In these situations foster parents often adopted the child, but acknowledged that this would not have been their first choice. This was especially true for older parents who never intended to nor wanted to adopt children, but did so because they had become emotionally attached to them. This problem is reflective of poor communication between social workers and foster parents, and adds to foster parents' sense they were not valued as team members.

DCF view of foster parent role. All of the foster parents participating in this study were asked, "how do you think DCF sees your role as a foster parent?". The responses pointed to disparities between the way foster parents conceive of and fulfill their role and duties and their role as communicated by DCF social workers. Answers to this question also reflected systemic and relationship problems addressed earlier in this report. The foster parent's ability to provide child care is compromised by such problems as:

- poor communication between social workers and foster parents;
- lack of foster parent participation in important case management decisions;
- lack of social worker contact with foster parents and foster children;

- foster parents' fear of retribution if they challenge practices they see as contrary to a child's needs; and
- an overall sense that the relationship between social workers and foster parents is adversarial rather than supportive.

Most foster parents spoke of at least one worker with whom they have or had a positive relationship. When speaking about a positive social worker-foster parent relationship, foster parents pointed to the ways in which a collegial relationship facilitated service delivery to a child and a child's family. Foster parents who felt supported by DCF reported they were more likely to be able to effectively handle very difficult children. When foster parents felt they not only had to contend with a child's severe acting out behavior or serious health problems, but a contentious relationship with the social worker, they were more likely to become overwhelmed and many would then terminate the placement.

Many foster parents expressed deep frustration and anger at the ways they saw DCF social workers defining foster parents' roles and duties. Foster parents felt they brought considerable expertise to their fostering, either through their personal experience or their professional training, but were not given the autonomy or recognition they felt they needed. One parent stated: "Their [DCF social worker] attitude is that you're the foster parents, you toe the mark. And you do what I tell you to do. And if we tell you to march, you march". In a sentiment echoed throughout the sample, the same parent stated she believed foster parents were treated like: "Trash. I think they [DCF] have no respect, no regard for foster parents."

Other foster parents expressed their deep concern at the way in which foster parents were being defined in terms of the payments received rather than services provided. One foster father stated;

> [Social workers think] you're not in it [foster care] for anything except the money. I really don't think that they understand that our hearts are right there. I can't say in all cases, because I do know of some foster parents that do it that way [for money]. But in 80 percent of the cases, you know, our hearts are right there. And I don't think that they understand that when you're shifting a child out of your home it's not only the child suffering. It's us suffering. It's the biological parents because their contacts have now been broken. Everybody suffers. It's a no-win situation.

Foster parents stated that because DCF social workers often failed to acknowledge the affective relationship that grows between foster parents and foster children, follow-up contact after a placement has ended is non-existent. While many foster parents expressed they would like to know how their former foster child is doing in his or her new setting, this was never possible. One mother stated: "but we didn't expect any [follow-up information]. You know, we are a facility. You've got to keep that in mind, because they're going to keep reminding you. You're not a human being, you're a facility". Parents interviewed described foster care in the following ways:

> A baby sitter, basically. As someone that would just, you know, we'll drop these kids off and if we never get back to you... We've had workers just drop them off and say "here you go" and you don't hear from them; or
>
> You have no rights. You're a glorified babysitter; or
>
> I don't think they see me. Basically, at DCYS [DCF] I'm *just* a foster parent. That's all. I feel as far as them, I'm just here, and I have her [foster child], and that's that. Other than that, the only contact is maybe once a year or once every three or four years or something like that. Other than that, I haven't heard from them.

Others reflected these sentiments saying they were looked upon "as employees" or "as a number rather than a home." Another mother stated: "It's awful...I'm the one who sees what happens when she comes home from school and cries and vomits and is angry, you know? I feel foster parents should be listened to more. It's like, just throw this kid in [your] home and [you] take care of her physical and emotional well being, but you have no say in anything....no matter what you say and do, it's not up to you. Who is here with this child?"

The way foster parents were defined through interactions with social workers stood in direct opposition to the way in which they saw themselves. Most foster mothers felt their most important task was to simply, "be a mother" and to provide a family for the child with a normal routine, good physical and emotional care, and love. Most foster parents talked of treating foster children, "just like their own." One interviewed foster mother stated:

> The most important thing that I do? Gee. I think everything I do for these kids is important, like showing them love, you know, feeding them or clothing them, you know washing them. The normal things I would do for my own children. So everything I do for them I think is important. You know, mothering.;

Another foster mother stated:

> I don't see myself as a foster mother, because I don't believe there is anything such as a foster mother... I am just a mother that had to step into a situation where there was no mother. Foster to me means substitute and I am not a substitute. I am the real thing. I am all that you've got when you are here. When you leave this situation, if you leave it, and go back to your mother then ok.

The program review committee interviews found evidence of a strained working relationship between foster parents and DCF staff. A rift exists between the role that foster parents want to play and the one they believe the department allows them to have. There are many long-standing, contributing factors. Overall it is the department's lack of organization and effective management of the foster care system. The department greatly relies upon foster parents but has not emphasized, through policy or procedures, this need to its staff.

From the interviews it became clear foster parents do not feel part of the team nor do they feel welcome to actively participate in the children's treatment case work. In fact, interviewed foster parents generally were unsure as to their role within DCF and morale was low. They were reluctant to voice opinions for fear of retaliation by DCF. Many foster parents explained they provided better care to the children and their lives were less complicated without DCF involvement. There is a mutual lack of respect between foster parents and social workers.

The program review committee found several influences prohibiting a successful working relationship between foster parents and social workers. These include: a lack of ongoing and effective communication; the failure of the case management process to gather sufficient information regarding the children and to provide foster parents with the information; an inability on the part of DCF staff to maintain frequent and consistent contact with foster children and parents; a lack of training for foster parents; and the disparity between the department's and foster parents' views on foster care.

As stated previously in this report, the department lacks a coherent organizational design to adequately care for the children in out-of-home placements. Because placing a child in foster care is the most intensive involvement an agency can have in a family and child's life, such involvement must be well planned and carefully monitored. Sufficient information and contact with the children and foster care providers is extremely important. Once the child is removed, the emphasis on minimizing the trauma to the child must be continued through a collaborative relationship between the two parties. Foster parents must be accepted as professionals and partners with DCF in providing out-of-home care.

To improve the existing working relationship between foster parents and DCF the Legislative Program Review and Investigations Committee recommends the department clearly define the value and role of the foster parent in the foster care system in policy and procedure. The department shall communicate the change in policy to its staff and insure that compliance is carried out in case management and social work practice.

The recommendations addressing the department's organizational structure and case management relating to the foster care system will also help to improve the strained working relationship between DCF and foster parents. The department will be required to place a stronger emphasis on its foster care system and ensure that the social work practice follows the policy as set out by DCF and the consent decree. The creation of the Division of Child Placement Services will place a priority on foster care. A more effective and organized system will address many of the deficiencies in social work practice that affect the foster parent's ability to care for the children placed in their homes. Additionally, DCF will be able to institute the foster parent training and support programs set out in the consent decree.

APPENDIX A
DCF CONSENT DECREE

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Historical Background

In 1989, a federal lawsuit Juan F. V. O'Neill was filed on behalf of nine minors against the DCYS (now DCF). The suit alleged the department did not adequately protect the children it is required to care for in violation of the federal constitution and two federal statutes. Foregoing lengthy litigation, the parties involved agreed to an attempt at mediation.

The court signed the mediation order in July 1990. Under the consent of the parties, the order appointed a three-member mediation panel: one person selected by the plaintiffs, one person selected by the defendants and the settlement judge (Robert Zampano). The mediation panel was granted full and complete authority to formulate procedures and to take any and all action to resolve each issue or matter detailed by the lawsuit. The panel had until December 31, 1990, to agree upon a consent decree.

Upon resolution of the issues, the mediation panel was to prepare a consent decree which would provide for the appointment of a monitoring panel. The monitoring panel would be responsible for drafting and administering an implementation plan that ensured compliance with the consent decree.

The consent decree was signed on January 7, 1991. The decree covered all areas of policy, management, procedures, and operations of DCF. These areas included investigations of child abuse and neglect, foster care, other out-of-home placements, care for children who are placed in DCF care, and adoptive services. The decree also covers qualifications, training, responsibilities, workload, and supervision of departmental staff and internal systems operations such as case reviews, quality assurance, and data management.

Role and Function of Consent Decree in DCF Operations

Initially, the consent decree established the former mediation panel as the monitoring panel. The panel was given the authority to determine the specific methodology and pace for implementing the decree. The panel determined, promulgated, and approved policies, standards, procedures, programs, operating manuals, and staffing levels needed for compliance. It also established the funding levels needed to accomplish this. It decided all matters relating to interpreting the decree, and its unanimous decision was final. The decree stipulates that the state pay for all mandates.

The panel prepared the manuals required by the consent decree and approved by the court on September 1, 1992. On October 26, 1992, the panel was dismantled and the court appointed attorney David Sullivan as the court appointed full time monitor of the consent decree. The monitor assumed all the duties and authority of the panel. In addition, the court monitor is used as alternative mediator /resolution process for the case. This means that if the parties have a problem or concern regarding

compliance or progress they must first go through the monitor before going back to court. If issues cannot be resolved then they may go to court and the monitor will present recommendations to the judge.

To help with the implementation of the mandates, DCF created an implementation team, with a coordinator at central headquarters reporting directly with the commissioner and a regional coordinator in each region. The monitor has been provided office space in New Haven and has a number of employees to help with oversight. Among his staff are a full time implementation coordinator, a part time community relations coordinator, a part time computer specialist, and a service contract with a child welfare and program expert.

Consent Decree Mandates

The centerpiece of the consent decree is caseload reduction. As a result, DCF was required to hire and train additional social workers, case aides and supervisors to get the department within the nationally accepted caseload standards. As part of the decree, the department was to establish a training academy responsible for providing pre- and in- service training for all department social workers.

The second priority was establishment of a Single Statewide Computer System (SSCS). The main purpose of this system is to significantly reduce the time spent by staff on paperwork and make service delivery more effective. The estimated cost of the computer system is six million dollars, however, efforts are being made to ensure substantial federal reimbursement. The consent decree original due date for this was July 1995, however, implementation delays have pushed it to July 1996.

Another area of the decree is quality assurance. This system is part of major infrastructure changes. It is designed to systematically and comprehensively evaluate the services and practices of each segment of the department on an on-going basis. The monitor's office prepares quarterly status reports on the progress on implementation.

Currently, the monitoring office is involved in a project known as 100% Case Review. The purpose of this project was to prepare and design a comprehensive review of a statistically valid number of DCF cases and produce findings and recommendation. Among the issues to be reviewed are:

Whether all children in foster care as of January 1995:

were assigned to a worker?

had a current treatment plan and a current administrative case review?

have had a face to face visit with their worker within three months of the case review?

are in the most appropriate placement for their circumstances or that they are in corrective action status pending the availability of such placement?

have current documentation in their case records?

Whether all cases with children with three or more placements as of January 1995 have had their current placement reviewed via an all party conference to determine the appropriateness and to plan corrective action if indicated?

The project is expected to conclude in the fall of 1995.

Major Consent Decree Mandates

Training Academy. DCF must establish a centrally located, adequately staffed training academy which provides both pre-service and in-service training to new and existing staff. The training must meet nationally accepted standards. Training requirements and records must be compiled and computerized.

Pre-service training (PST). All new social workers must complete pre-service training during their first four months of employment. An individual training plan must be developed for each social worker within the first five days of employment. Cases must not be assigned to new social workers until pre-service training is completed.

In-service training (IST). DCF staff must annually receive five days of in-service training.

Foster Parent Training. Training must include: information, rules, data, advice regarding foster care program; meetings with experienced foster parents; and particularized training for children with special needs. Current foster parents are required to attend this training as condition of license renewal.

Central/Regional Offices. Central office is responsible for developing and distributing policies, procedures, and guidelines to carry out the day-to-day administration. The regional offices must administer child protective services.

Health Management Unit. This unit shall review, develop, and implement policies, standards, and proposals related to all aspects of health, mental health, and substance abuse. This includes establishing procedures for evaluating health care being received in out-of-home placements and reviewing the deaths of all children under DCF care or supervision.

Contracts Unit. This unit must be established in central and regional offices. It is their responsibility to compile and review all contracts, grant-in-aid and expenditures for services and programs. They must also monitor performance of grantees and contractors.

plan must also include health, mental health, and substance abuse treatment, if necessary, for each plan. Any changes made to treatment plan must be accepted by all participants.

The consent decree also sets out case management and supervision guidelines. These include:

- weekly personal visits of all children kept in their home during the first 30 days;
- after 30 days, alternating personal and telephone weekly contacts;
- weekly assessment of plan progress;
- personal contact with child within 48 hours after out-of-home placement;
- a foster child who has been in a home for one year cannot be removed without notifying foster parent of their right to removal hearing;
- allegations of abuse in foster home must be investigated immediately;
- develop special procedures to be used for children who have been repeatedly moved from foster homes because of behavioral problems;
- treatment plan cannot be terminated unless risk assessment shows that risk has been reduced to point that DCF supervision is not necessary;
- supervisors must meet weekly for one hour with social worker to discuss each case; and
- treatment manual must be developed and list the qualifications, experience and training required of social workers in this unit.

Family Training and Support Unit. DCF must set up this unit in each region. The unit is responsible for foster and adoptive home surveys, recruitments, orientations, screening, pre-licensing training, home studies, and licensing for foster and adoptive homes. The consent decree also requires that reimbursement rates be increased.

Adoption. Panel will prepare adoption manual. The manual will dictate time frames, criteria, and procedures for DCF to carry out voluntary and involuntary termination of parental rights. Also post-adoption services must be established with at least one adoption resource exchange worker in each region.

Regional Resources Groups. A regional resource group must be created in each region. This group consists of a psychiatric social worker, a nurse practioner, registered nurse, substance abuse counselor, and if possible assistant attorney general. This group would determine degree of risk to

each child, and if further intervention needed, provide expertise in treatment plan evaluation, and participate in case review and training.

Consultant. Consent decree allows the use of consultants when necessary.

Administrative Case Review. Quality assurance unit must thoroughly review cases every six months. The review must be done by quality assurance reviewer, the social worker, and at least one other person. Two weeks before the review the social worker must indicate who will participate in review.

Aftercare Services. This is mandated for all children returned to home. These services monitor child's welfare and provide support so child should not be removed again. It lasts from four to nine months. Panel will develop manual.

Regional Services. Panel will prepare guidelines for services to be available in regions. It sets limits on bed capacity at DCF institutions.

Paperwork, Information Management, and Technology. A committee must be formed to study the feasibility of reducing paperwork and reformatting forms and reports. This committee must assess computer needs.

Probate Court Order Studies. Decree requires that DCF ensure that probate court ordered studies be completed within mandated time frames. This is done to help eliminate court backlog.

APPENDIX B
FOSTER PARENT PROFILES

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FOSTER PARENT PROFILES

Profiles of six DCF foster mothers based on the program review committee interviews follow. The six mothers were selected because their stories reflected overall trends and opinions highlighted in the interview and coding process. Identifying information about the foster mothers and children has been deleted to preserve anonymity. The profiles present a variety of homes providing regular foster care, relative care, and emergency placement care.

Anna. Anna is a young black foster mother living in a large city. She is employed full-time. Anna is married and has three biological children, two of whom are living at home. She also cares for an elderly relative living in a separate apartment in her home.

Anna has been a foster mother for over two years to three relative children, who are all school age. A fourth sibling does not reside with Anna but is a constant visitor. Anna has been involved in the lives of these children since their births. She cared for the children on an unofficial basis on several occasions and finally they were placed in her home by DCF.

The children and their birth mother had a long history with DCF because of the mother's involvement with drugs and neglect of the children. In investigating a report to Careline, DCF social workers found the four children alone in an apartment and were unable to locate their mother. The social workers contacted Anna and asked her to take the children because they are her relatives. Anna was not licensed as a foster parent nor did DCF require her to apply for licensure.

During the first year, the children received AFDC payments which Anna said totaled $500 per month for three children. Although she was not a licensed DCF foster home, the children were considered to be an open case and monitored by department social workers. Anna was required to abide by DCF child care policies, such as the department's rules for discipline of foster children.

Anna stated it was very difficult for her family financially and emotionally during that year. Her own children were resentful that Anna and her husband no longer could afford certain items or family activities and that their time was now spread among five children. As parents, Anna and her husband had to adjust their lives to include the extra children. Activities such as attending church were difficult and time consuming because everyone would not fit into one car, so both cars had to be driven. All the children had to have proper church clothes and be bathed and dressed in the morning. The grocery bill increased. Anna and her husband worked different shifts in an effort to ensure the an adult was always at home with the children.

Anna stated that after one year, her family could no longer function or afford to care for the foster children. She asked DCF to license her as a foster parent and to reimburse her according to the foster care rates. The department repeatedly denied her request. Finally, Anna gave the

department an ultimatum: either license her or remove the children. She stated that it was a very emotional and difficult decision for her family because they all loved the three children.

The department finally began the assessment and licensing process for Anna. During this process, DCF social workers inspected Anna's home and interviewed her family. The final recommendation was that Anna could not be licensed until major remodeling was done to the home. Anna observed that as long as she was just a relative her home was safe, but as a foster mother, the home was no longer appropriate. At no time during the licensing process were the children removed from the home. She and her husband were very angry and frustrated but complied and completed the construction.

Anna was licensed and began to receive foster care payments for each child. Anna was not reimbursed for the first year of care she provided to the children. However, she said the increased amount of payments eased some of the strain on her family. It allowed her to buy a minivan after selling one of the smaller cars.

It was DCF policy, at the time Anna was being assessed and licensed, that foster parents attend a training session. Anna and her husband were not aware of this nor did they ever receive any training. They do not attend support groups for foster parents and have never been contacted by a support social worker.

When asked about her relationship with DCF social workers, Anna stated she rarely sees them. The frequency with which the workers visited did not increase after her licensure. In fact, she could not remember the last time she saw the children's social worker. Anna recalled an incident a few months earlier that typified her working relationship with DCF social workers. The children's treatment social worker had made an appointment to visit Anna on her scheduled day off from work while the children were at camp. Anna waited several hours past the scheduled time for the worker to arrive and then she left to do errands. The social worker arrived while she was gone and left a note on the door. Anna has not seen or heard from the worker since that incident.

During the visits with a social worker that did occur, Anna stated that the worker spent very little time with the children except to visually inspect them. The rest of the visit was spent with Anna discussing the children's problems adjusting to the new home life.

Prior to her licensure as a foster parent, the three foster children had been attending therapy sessions which were paid for by DCF. Shortly after receiving her license, Anna was informed by the therapist that the department had stopped payment on the sessions and that Anna had an outstanding balance for the times Anna participated in treatment. Anna refused to pay and contacted DCF to begin the children's therapy again. She explained that the children exhibited very unusual behaviors and had extreme reactions to such things as routine discipline. One of the children was a bed-wetter. Anna had seen an improvement in the children's behavior during the time they were in therapy and also noticed a relapse after it was canceled. Anna has yet to receive a reply to her request on behalf of the children.

Anna and her husband have made all decisions regarding the children's educational and medical needs without DCF assistance. For example, one of the children attends a private school rather than public school. Anna takes the children to her family doctor. The children's medical passports were never completed. Anna was given a medical passport for each child that only contains the name and birth date. Anna said since she is a relative, she knows the medical history of the children. However if she were a regular foster parent she would not. She received the children's Title 19 medical cards, which pay for medical care, six months after they were placed.

Anna received a letter from DCF informing her that the parental rights of the children's mother will be terminated, and she must contact the department if she wants to adopt them. She and her family have agreed to adopt the children.

Anna discusses their biological mother and foster care with the children. She wants the children to have some type of relationship with their mother, although they must know that she will never care for them. The children do not call Anna "mom". However, they introduce her and her husband as their parents. Anna also considers them to be her children but is respectful of their relationship with their birth mother.

Anna and her husband have decided to continue providing foster care to non-relative children after their biological and current foster children are grown. She feels it is important to provide a safe home to children.

Beth. Beth is a older, married black woman living in an urban area. Her own children are grown but live in apartments in the same building as Beth. She works full-time outside of the home.

She has been a licensed DCF foster mother providing regular foster care for one year. She has cared for six children during that time. At present, she is caring for two foster children and her grandchildren.

Beth became a licensed foster mother after an incident at her work place. Beth worked in a public building and noticed a small boy left unattended. After several hours, the boy was still alone and Beth considered taking him home at the end of her day. She did not because she was concerned she would be breaking a law so she contacted the police. Beth and the police learned that the boy and his sister were abandoned by their mother. The two children were separated, and the boy was taken into custody of DCF. After that incident, Beth contacted the department and ultimately was licensed as a foster mother.

Beth explained that five of the children were placed in her home with one to two hours notice by DCF. She was given a few days notice with one of the foster children. She received very little prior information about the child other than the name, sex, and age.

She explained that the social workers are supposed to follow up on a placement and provide more information. However, her experience has been that she must call the department rather than

wait for a worker to contact her. She usually gets no additional information. Beth is concerned about medical information especially since she has more than one child in the home. She has found that DCF and doctors are reluctant to provide her with medical information because it is confidential, but feels as the child's caretaker she should be told of any medical conditions.

For example, Beth described a child placed in her home suffering from a rash. After repeated efforts to get a medical passport, she received the incomplete paperwork with no mention of the rash. She took the child to a doctor who would not tell her the diagnosis. Although she allowed the child to remain in her home and treated the rash as directed by the doctor, Beth was uncomfortable and worried about spreading the rash to the others.

Beth stated that the initial placement in a foster home is difficult on the children and that, in her experience, DCF social workers do not take enough time to talk to the children. The placement of one of the first children in her home was very traumatic. Beth received a call from a social worker and agreed to accept the child. The workers arrived, and the child was hysterical and refused to leave the car. Beth described the workers physically pulling on the screaming child to leave the car. After several minutes, Beth asked the workers to stop, and she began speaking to the child. She told the child his mother was not feeling well, and that she was going to take care of him until his mother got well. She asked the child to come into the house because the other children were having a good time. Eventually, Beth stated, the child left the car and came into the house.

Beth explained that all the children are quiet and withdrawn when first placed. She usually takes children for ice cream, which makes them happy. She feels that eventually they adjust to the home. Beth has certain things that she does to make the children feel at home, such as dollar day. Every Friday Beth takes the children to the dollar store and lets each purchase a toy.

Currently, Beth is caring for a young child who has been in her home for two months. The child was placed after the mother was incarcerated. Beth said she knows the child's name, age, and reason for placement but has received no information on the educational or medical background, the birth family, and does not even know the child's date of birth. She does not know the name of the child's social worker, and the supervisor she was dealing with has been transferred. Beth said she relies on the DCF driver, who transports the child to visits with the mother, to give her information.

Beth described the child as a "street kid" who has no structure in his life with his mother. She has found it difficult to teach the child to live in a structured home life. The child receives no therapy or treatment, and after visits with the birth mother, is out of control and very difficult to handle. Beth's grown children help her with the child. Beth is waiting for the social worker to inform her the child will be returning to his mother.

Another pre-school child in her care has been in the home for almost a year. Beth is actively involved with the child's case and has gone to court proceedings involving the child's commitment status. She attends all DCF meetings regarding the child and is involved in the pre-school. Beth is proud that she was named "Best Mom of the Year" by the pre-school staff.

Beth stated she had a good relationship with the initial social worker assigned to the child but is finding it difficult to work with the new worker. She feels the social worker's primary focus is the mother rather than the child because of the goal of reunification.

Beth has seen the child's behavior change as a result of psychiatric treatment. When first placed in her home, the child would react to structure or discipline by hurting himself. Beth described the child banging his head on the table or wall and beating himself his fists. The child also struck out at others by biting them. Beth was concerned because he showed no sign of physical pain when injured. Although bleeding, he would not acknowledge the injury. Now he shows restraint by not hurting himself or others but still reacts badly to strangers.

Beth described the child's extreme reactions to strangers to a social worker, and had the support of his doctor, therapist, and pre-school teacher. The social worker insisted the child visit a parent he had never met. As Beth expected, the child had a serious reaction to the visit. Beth also feels the plan to reunite the child and birth mother will produce similar reactions from the child unless there is a plan to slowly introduce the mother back into the his life.

Beth requested the removal of one of the children placed in her home because she could not handle the child's tantrums, which she described as severe. The school-aged child was placed in her home with only a few hours notice. The social worker informed her the child was hyperactive and on medication, but did not give Beth any information about the child's behavior or past experiences in foster care.

During the first night, the child cried a little but cooperated the next day and went to school. Beth went to work, but during the day received a call from the school about problems with the child. Beth left work to meet with school officials who informed her that the he had been passing out money to the other children.

Upon returning home, Beth found that a container of loose change and dollar bills had been taken from her room. She confronted the child, who went into a rage and became uncontrollable. Beth attempted to contact the social worker but instead reached the supervisor. The supervisor asked Beth if she knew about the child's problem Beth stated she did not. The supervisor told Beth the social worker was aware of the problem and should have informed her that the child had been released from a psychiatric hospital prior to placement in Beth's home and was violent and acted out sexually against other children. Beth told the supervisor to come and get the child because there were other children in her home, and she was concerned for everyone's safety. Beth was very angry that DCF was aware of a serious condition with the child and did not inform her prior to placement.

Beth's experiences with the children's social workers has been limited. She said when they come for a child, they do not enter her home. After ringing the doorbell, the workers take the child and leave for the visit or doctor's appointment. They do not come into the home when returning the child. In most instances, it is not a social worker but a transportation aide who picks up the child.

Beth described one incident with a child currently in her home that showed the lack of communication between DCF and foster parents. The child is school-aged but was not registered to attend school. Beth had attempted to contact the social worker to get the necessary educational and medical documents to register the child in public school. However, she received no reply or assistance. She then began to speak to the transportation aide who had been taking the child to visits and therapy. The aide informed Beth that the law stated foster children did not have to go to school until they were seven years old and Beth should not worry until the child reached that age. Beth knew that was not true. She was still unable to reach anyone within the DCF regional office assigned to the child's case. At the time of the interview, the child was not attending school.

Cory. Cory is a middle-aged, married white woman. She and her family live in a house in a suburban neighborhood. She has grown children and young grandchildren.

Cory experienced a difficult childhood growing up in the foster care system. She became a foster mother to help other children. She has been providing foster care for two years and cared for five children. She provides regular, short-term foster care and prefers children up to the age of eight.

Until recently, Cory cared for a pre-teen child who was in foster care because of sexual abuse in the birth home. The child was removed from a foster home after six years of placement because of sexual abuse by the foster parents. Cory explained that the child had no structure in the previous foster home and was unable to conform to a family lifestyle, such as regular bedtime, curfews, and rules about playing in the neighborhood. The child acted out sexually around men.

Cory had to withhold privileges from the child, such as an allowance because the child would save the money and use it to run away. Cory stated the child was a "time bomb" and would have serious tantrums in response to any limits. The child was on medication and in therapy. Cory asked the social worker to increase treatment, and the doctor concurred. DCF, however, refused the request claiming the child was "not bad enough." The department also stated that perhaps it was Cory's parenting skills that were causing the child to act out. DCF did offer the services of a parenting aide to critique Cory's parenting and offer alternatives. Cory refused this service because the aide was scheduled to work during the family's dinner time and Cory felt that was too invasive.

As another alternative, Cory then requested that DCF place another child in her home because she felt that an age-mate might help the child. She felt the child was lonesome because there were no children her age in the neighborhood. The DCF social worker refused saying that the child need one-on-one attention from Cory. At this point, Cory felt that she was not only fighting the child, but also DCF, because the social workers were verbally abusive and threatened her.

After several months in Cory's home, the child was freed for adoption. Cory told the child and DCF that she did not become a foster mother to adopt a child. The child ultimately was placed with an adoptive family. Cory has learned that the child has since stabilized and is off medication.

During this placement, Cory stated she felt helpless and embattled. She could not get the child's needs met by DCF and considered her role to be the child's advocate. Cory has since refused to care for sexually abused children. She further stated that she was not trained to care for this type of child.

Recently, Cory cared for two young children who were placed in her home on an administrative exception because they were of a different race than she. The placement was for 60 days, during which time DCF was to locate a foster parent of the same race as the children. Although she accepted the terms of this placement, Cory was angry that the children could not remain in her home. She felt that they were receiving good care and were well-adjusted to the placement. Cory stated that another move based solely on race was unnecessary.

Currently, Cory is caring for two pre-school foster children who are involved in several therapeutic and educational programs because of their physical and emotional needs. One of the children has started to visit the birth mother according to the DCF plan for reunification. Cory said the visiting plan was difficult for everyone to adjust to because the child's behavior was very disruptive after visits. The birth mother was resentful of Cory's relationship with the child and this interfered with the child's adjustment to foster care. The child became confused about where his home was and who his parents were. Cory explained to the child that his home was where his toys were. She further explained that some day his toys would be at his mother's house and that would once again be home. Cory stated this helped the child adjust to the visitation schedule.

The second child was removed from a long-term foster home and placed with Cory for reasons she did not know. She did learn that there were issues regarding the previous foster parents' right to adopt the child and until this was settled the child was placed with Cory.

The child has a physical handicap affecting his motor skills and a speech impediment. The child was placed with no medical history or records, although therapy was part of the foster care treatment plan. Cory tried unsuccessfully to get the medical information from the social worker. Eventually, she took the child for a physical to her family physician and learned the speech impediment could be corrected through surgery.

Cory attempted to get the necessary approval for the surgery. Because the surgery was deemed non-essential, the previous foster mother, who was attempting to adopt the child, had to give her authorization, and she was reluctant. Ultimately, authorization was obtained, and the surgery was done.

Cory's understanding is that eventually the child will be returned and be adopted by the previous foster mother. Cory hoped to continue her relationship with this or any foster child. She maintains an open-door policy for the foster children she cares for.

Drew. Drew is a middle-aged black woman who lives on a residential street in a city. She is divorced, the mother of four biological children, and a grandmother. Drew is a full-time foster

mother who has been providing emergency foster care for DCF for 10 years.

After leaving a full-time position, she worked on a temporary basis until a friend recommended she apply for a foster care license. She decided to provide emergency care because the placements were of short duration, and she could be selective in the children she chose to accept. During an investigation, DCF maintains immediate emergency placement homes for those children removed from their parents' homes. Usually, a crisis situation results in severe child abuse or neglect requiring removal of the children. The emergency placements provide for the safety of the child while DCF locates the most appropriate placement.

Drew has provided care to 10 children and, contrary to DCF emergency placement policy, most of them remained in her home for long periods of time. At the time of the interview, Drew did not have a child in her home but she had contacted DCF to notify them she was available. Drew takes time in between placements to build up her emotional stamina. She gave two reasons why she provides foster care: (1) as a source of income; and (2) to assist children in reuniting with their families.

Drew cared for two school-aged siblings who were removed due to sexual abuse by the parent's friend. The children were placed in an emergency situation and arrived at Drew's home in the middle of the night. The children brought with them numerous plastic bags of dirty clothes, which Drew spent the rest of the night washing. She wondered why, if this was an emergency placement, the children were brought to her with all of their belongings.

After several days, Drew contacted the social worker and asked when the siblings would be placed in a regular foster care home. The social worker asked if she would allow the children to remain in her home, and Drew agreed. She was informed that the children were removed due to the mother's boyfriend; however, the man was not alleged to have abused the children. Drew was uncertain why the children were placed in foster care and suspected it was a conflict between the mother and social worker.

One day, the children were playing in the playground. One of the children returned home for lunch and Drew sent her out to bring the other child inside. The first child returned saying her sibling was not in the playground. Drew went to find the child and asked the neighbors if they had seen the child. Drew finally found the child sitting on a guard rail along the highway.

Drew asked the child why she was there and the child responded that she was thinking of killing herself. Drew asked why, and the child said she was "not clean." The child proceeded to tell Drew about sexual abuse by the mother's previous boyfriend. Drew was able to calm the child and get her to return home.

Drew contacted the social worker and expressed her anger about not being told the child's background. She felt that without adequate background information it is difficult to respond to the

child's behavior. That is, foster parents need to know what is causing children to behave in a certain way which will affect the parenting.

The temporary arrangement for the siblings lasted for a few months until they were ultimately reunited with their mother.

In another placement, shortly after speaking with a DCF worker, two police officers brought her an infant. The baby, clothed in a diaper and T-shirt, was not wrapped in a blanket even though it was winter and the middle of the night. Neither the police nor DCF provided any supplies, diapers, or formula at the time of placement.

Another emergency placement involved a relative child and two non-relative siblings of Drew's. She was familiar with the children because of the family relationship. The children remained in her home for almost one year, during which time Drew dealt with the biological parents who caused some problems in her home, such as calling and visiting at odd-hours and using drugs and alcohol while in the presence of the children. The family was ultimately reunited although Drew felt that the mother was not fully prepared to care for the children.

Drew has routinely asked social workers not to give her address or telephone number to birth parents, since it often means she has had to deal with angry and emotional parents. She feels it is not the foster parent's job to interact or mediate with the birth parents.

Drew explained that during her years as a foster mother she has had very little contact with DCF social workers. Further, she received almost no information on the children placed in her home, but accepts that the emergency situation resulting in removal of the child prohibits the collection of information. However, she feels the department does not provide support or information to foster parents after the crisis.

Despite her 10 years of providing foster care, Drew was unaware that the department assigned support social workers to foster parents. She explained, though, that after the recent media attention focused on foster care, a support worker did visit her home, and the children's social workers began to contact her more frequently.

Drew does not attend foster parent support group meetings because they are held too far from her home. She said she can not travel an hour to attend a meeting. Support group meetings sponsored by another region are held closer to her home, but she does not know if she can attend a meeting outside of her region.

Eleanor. Eleanor is a young white woman, who works full-time. She is married with three biological children living at home, in a single-family suburban house. She has been a licensed foster mother for two and one-half years and has cared for 15 foster children. Eleanor provides regular foster care along with respite care for other foster parents.

Presently, Eleanor is caring for three foster children: an infant, pre-schooler, and a school-aged child. The school-aged child was just placed in her home, and she knows little about her. She stated the social worker did not know the child's age or have any medical information. Eleanor got most of the information directly from the child. The child is hyper-active but none of the workers knew when she had last been medicated. She was placed in foster care as a result of sexual abuse by a family friend. Her birth father is missing.

Eleanor said that she was dealing at present with an intake protective services social worker; nothing would be done for the child until a treatment social worker was assigned, which may take several days. Eleanor thinks the child should be examined by a physician for signs of a sexually transmitted disease, but knows that until the social worker reviews the case a physical will not be scheduled.

The pre-school child has been in her home for two years, since he was four months old. The child entered foster care when his mother gave him up for adoption after he was born. However, when the child was six weeks old, the mother was incarcerated and stopped the adoption process. The mother requested visitation privileges, which were scheduled for once a month at the prison. The child also visited the maternal grandmother once a week. The birth father was also incarcerated.

The reunification plan was that the mother would, after being released from prison, reside with her mother, and both women would have joint custody of the baby. Upon being released from prison, the mother disappeared for 14 months with no contact with the child or DCF. The maternal grandmother then refused custody and to care for the baby.

The birth father, who was also in prison, then requested visitation rights. Visits were held once a month at the prison. After his release from prison, the father requested custody of the baby. The DCF reunification plan involved twice weekly visits and specific stipulations for the father, such as employment and housing. While this treatment plan was in effect, the father visited the child twice in one year. DCF began the process to terminate the parental rights of the birth mother and father. Eleanor and her husband wanted to adopt the child.

Eleanor then learned the mother was again in prison and had requested to resume visitation. DCF granted visitation privileges and a transportation aide took the child to the prison to see his mother for one hour a month. Eleanor stated that the child reacted badly to the visits because he did not know his mother and was afraid. The birth mother also reacted badly to the child's reluctance to go to her and stated she did not want to see the child again.

The birth mother again changed her mind and asked to resume visitation. The father's whereabouts were unknown. DCF postponed the termination of parental rights for another 18 months and changed the case goal to birth family reunification.

Eleanor stated this child has had five social workers assigned to his case during two years and numerous transportation aides to take the child for visits. She explained the child is very frightened

of strangers and reacts badly to the DCF staff by crying and screaming. Eleanor was prohibited by the social worker from accompanying the child on the prison visits because the child will not approach the parent if she is there.

She feels the child has no rights in this situation. The child will scream during the drive to the visit and during the visit with his mother. The child then returns to his day care center and will act out by hitting and biting other children. When Eleanor picks the child up at day care he clings to her for the rest of the evening. Eleanor feels it is very unfair the birth mother is given several chances to get her child back, given the child does not know or identify with his birth parent. She still is hoping to adopt the child because she thinks the mother will not be able to comply with the treatment plan.

Eleanor has had almost no contact with a support social worker and does not understand what the social worker's role is in foster care. Since the support worker does not know each child's case, Eleanor doesn't think the worker can be much help.

Eleanor believes the DCF policies on child care are rigid and don't account for normal family interactions. For example, she was told that foster children are not allowed in the foster parent's bed. However, every Sunday morning her biological children get into bed with her and her husband. She does not feel that she can exclude the foster children because they are part of the family. In another example, she was told during DCF training that biological and foster children can not bathe together. Eleanor's experience has been that when her young children are taking a bath the young foster child cries when excluded from the activity. She solved this by making the children wear their bathing suits in the tub.

Gina. Gina is an older, married, white woman. She has one biological child and one adopted child who was in foster care. She is also caring for her elderly mother. Gina works part-time. The family lives in a suburban area.

Gina has been a foster mother for almost five years and has cared for only three children. She provides regular foster care.

Her first foster child was placed in her home directly from the hospital. The baby was drug and alcohol addicted with numerous health problems. During the first year of placement, Gina brought the baby to the DCF office twice a week for visits with the birth mother. The mother frequently did not show up for the visits. Gina stated the mother and baby saw each other only on 16 occasions in one year. At the end of the 18-month commitment period, DCF began the termination of parental rights process. Gina told DCF she and her husband wanted to adopt the baby.

DCF told Gina that because she and the baby were of different races the adoption would probably not be authorized. DCF looked for a same race adoptive home but because of the baby's severe health problems and the necessary care involved a suitable home was not found. Gina explained the baby has central nervous system damage that, among other things, does not allow the child to sleep through the night. The child also has special education and physical therapy needs.

DCF finally allowed Gina to apply for adoption, and after a three-year period involving many hearings and reviews the adoption was granted.

Three years ago, two pre-school children were placed with Gina. The children were not related. One of the children was involved in a visitation problem with the birth mother. Gina developed a relationship with the birth mother and tried to help her meet the treatment plan goals. She gave the mother furniture and other household items to help her set up an apartment, and allowed the mother into her home to see the child. The mother had to complete a drug rehabilitation program before reunification with her child.

Before entering the rehabilitation program the mother visited at Gina's home. Gina gave the mother and child some time alone to say good-bye. While Gina was in the other room, the mother took the child and left. Gina's husband followed in his car but was afraid the mother would hurt the child if he continued. Gina notified the police and DCF. Cocaine vials left by the mother were found in Gina's bathroom. The child had been in Gina's home for four months before he was taken.

After one week, the police located the mother and child in another state. The mother was arrested, and the child was returned to Gina's home where he remained for one year during which time the mother was in prison. Gina took the child to visit the mother during the year.

The mother was released from prison and resided in a half-way house. The visits schedule increased to two week-ends per month, involving an over night stay. The child did not want to visit his mother and was attached to Gina. Gina encouraged the relationship with the birth mother. DCF reunited the mother and child after longer and more frequent visits. The mother and child lived together for three months. During that time, DCF was informed that the child was not attending school, was neglected, the mother had been evicted and was homeless, and she was back on drugs. The birth mother disappeared. The child was once again removed and placed with Gina.

Gina stated that, upon returning to her home, the child's behavior had changed. The child was angry and difficult to handle. The child felt betrayed by Gina because she let him go to his mother and he was not cared for properly. The child asked Gina if, when he had been with his mother, she heard him calling for her. Gina said no and asked why the child had wanted her. The child said he had been hungry and wanted Gina to feed him. Gina said this was very difficult for her emotionally.

DCF recently located the child's birth father who had been making support payments. The father is remarried and has other children. There was a gradual introduction between the child and father that increased to visits of several days. Finally, the child and father were reunited. Gina said the process worked well and that the child keeps in contact with her. The father also maintains weekly contact with Gina.

The foster child currently in Gina's home has been there for three years. She said the child's treatment plan has changed significantly during the time he has been in her home. Initially, the goal was reunification with the birth parents. The birth parents failed to complete any requirements and

did not appear to be suitable to care for the child. DCF began the termination of parental rights process and the child will be free for adoption by the end of the year. Gina does not want to adopt the child.

The child has severe neurological damage and is learning disabled requiring constant care and supervision. The child knows that he will be adopted and live in another home. Gina said he is well adjusted and appears to enjoy living in her home. She has explained to the child that she can not adopt him. Gina is willing to care for the child until a suitable adoptive home is found and the transition is made.

APPENDIX C
RIGHTS AND RESPONSIBILITIES

APPENDIX C. Rights of Participants in the Foster Care System.

Child	*Foster Family*	*Birth Family*	*DCF*
To respect as an individual.	To be a participating member of the foster care team.	To respect as an individual and parent, confidentiality, open and direct communication.	To protect children.
To have regular contact with birth family and others in significant relationships unless prohibited by court.	To be able to accept or reject a child for placement in their home.	To legal representation in all matters affecting the health and welfare of their child, including the right to appeal all court and DCF decisions.	To provide preventive services.
To receive complete information about plans and decisions and to be involved in decision-making as appropriate to age and situation.	To have written information that is necessary to provide proper care and supervision for the child (e.g.: medical or behavioral info) and for those children placed under emergency situations that information shall be provided within one working day of placement.	To participate as a member of the team in the development of the treatment plan, attend administrative review of plan, and receive a copy of the plan.	To investigate abuse and neglect of children without infringing on the civil rights of the child or birth family.
To have bodily privacy relevant to growth and development.		To be included in plans for the child's placement, visitation, and permanent plan.	To provide reasonable efforts to prevent placements.
To have developmental needs taken into consideration regarding decisions, expectations, and consequences.	To request pre-placement visitation in non-emergency situations.	To be informed of any court proceeding concerning the custody of the child.	To place children in the least restrictive environment.
To have confidentiality about themselves and family and to share that information with the foster care team as needed.	To know if the child is infected with a communicable disease.	To have their child placed in an environment which meets the child's needs and is consistent with his religious, cultural, ethnic, and linguistic background whenever possible.	To provide health services.
	To deny anyone access to their home, except for DCF.		To provide juvenile justice services.
To have access to an attorney, social worker, and clergy.	To be included in planning meetings and appointments in order to lessen the disruption to family routine.	To consistent visitation or contact within predetermined guidelines, until the child returns home, parental rights are terminated, or visits are otherwise restricted by court order.	

APPENDIX C. Rights of Participants in the Foster Care System.

To be notified of any legal actions DCF pursues for the child placed in their home and any change in legal status.

To family privacy and confidentiality, and the right to maintain their own child-rearing practices as long as they do not conflict with DCF regulation or policy or the child's needs.

To be informed of the process for removing a child from the foster home, investigation of allegations, revocation of license, and other proceedings.

To have telephone calls and other communications responded to in a timely fashion and requests made on the child's behalf acted upon promptly.

To receive information from the caseworker on their child's health, development, progress in school and behavior.

To notification as soon as possible of any emergency involving the child.

To challenge DCF treatment plan via administrative hearing.

To have their child returned to their home when the necessary changes required by the court or DCF have been made.

Source: DCF policy manual, vol. II, chapter 41.

APPENDIX C. Responsibilities of Participants in Foster Care System.

Child	*Foster Family*	*Birth Family*	*DCF*
To be responsible for his own actions.	To provide a safe, nurturing, and stable environment that is free from abuse and neglect where children feel respected, valued, secure, and accepted for who they are.	To be a participating member of the team that creates the treatment plan.	To provide pre-service training, licensing, and continuing education.
To respect other's rights and property.		To prepare and participate in the child's placement.	
To put forth an honest effort to make the placement work relevant to his age and development.	To promote the child's physical, medical, and emotional well-being, and help child to reach potential.	To be working on the solutions to the problems preventing the child from returning home.	To provide foster parents with sufficient information about a foster child prior to placement so they can determine whether to accept the child.
To refrain from violent behavior.	To respect family traditions, religious, linguistic,cultural, and racial heritage of the child and birth family and to encourage the child to understand and accept.	To comply with court orders.	To provide foster parents with sufficient on-going information to enable them to provide adequate care and to meet child's needs.
To refrain from the use of drugs and alcohol.		To inform the social worker about major changes.	
To bring home report cards and notes from school.	To communicate to the child house rules, responsibilities, and consequences.	To provide financial responsibility for the care of the child.	To assign a social worker for child's case management and a social worker for support of foster family.
To go to school and follow rules.	To support and value the relationship between the child and birth family.	To support a positive placement which is in the best interest of the child for as long as necessary.	To have social worker develop a relationship with child through direct contact and private conversation.
	To support reunification or alternative treatment plans.	To discuss the child's care and progress with the social worker.	To involve birth parents as a team member in pre-placement activities, treatment plan, administrative case reviews, and court proceedings.

APPENDIX C. Responsibilities of Participants in Foster Care System.

To help with family chores according to his age and development.

To communicate with the social worker about how they are doing.

To cooperate with scheduled appointments (medical, therapy).

To be open in all communications (introduce friends to foster parents, tell foster parents where they are going, telephone, chores, homework).

To support visits between foster child and family out of foster home as arranged by social worker.

To protect the child from any abusive, neglectful, corporal, humiliating, or frightening punishment or treatment.

To take part in implementing the child's treatment plan and case reviews.

To maintain confidentiality in all matters concerning the child and family.

To participate in the court process.

To take part in DCF training programs.

To request help and support when needed.

To schedule and keep appointments for child's routine medical and dental care.

To coordinate with the child's social worker for therapy appointments and to participate as needed.

To maintain contact/visitation with child as a time and place arranged by the team and foster parent.

To contact foster parents in advance if they are to be late or to change appointments.

To keep appointments with the social worker and other service providers.

To arrive in a timely fashion and act appropriately for all contacts with child.

To provide financial reimbursement and medical coverage for care of the child.

To provide foster parents with necessary medical information and instruction regarding the care of child.

To provide foster parents with a Medical Passport for each child.

To delegate to foster parents the right to arrange for and authorize routine medical and dental care.

To inform foster parents of available medical coverage.

To arrange in consultation with foster parents, for therapeutic care.

To maintain and respect confidentiality of foster and birth families and child

To supply foster family with necessary information for school placement.

To respect foster family privacy and right to maintain child-rearing practices.

APPENDIX C. Responsibilities of Participants in Foster Care System.

To arrange for emergency or specialized medical treatment and provide routine medical, nutritional, and emotional care.

To take part in child's educational development through contact with school.

To comply with all DCF regulations and policy.

To advise regional office of any other affiliation with other child placement agencies and receive prior approval for other children to be placed in the home.

To give DCF notification about major changes at least 60 days in advance.

To obtain DCF permission before taking foster child out of state.

To give up the care of foster child to no one but DCF unless ordered to do so by the court.

To notify DCF of overpayments.

To communicate problems to the social worker before the situation becomes a crisis.

To make available to foster parents annual re-licensing and other reviews of the home.

To inform foster parents of process for removing child from home, investigation, revocation of license, procedures for registering complaints, and appeals/

To supply information regarding procedure for filing for reimbursement of damages caused by child.

To maintain a comprehensive case record on each child.

To notify foster parents of legal actions involving child in their home.

To develop permanent plan for child if reunification is not possible.

To give foster parents criteria for adoption of foster child.

To notify foster parents in advance of removal of foster child from home.

APPENDIX C. Responsibilities of Participants in Foster Care System.

To give advance notice if removal of the child is desired except when immediate removal to ensure life, health, or emotional well-being of the child or foster family is needed.

To maintain accurate records of anything significant regarding foster child.

To keep foster family physically and emotionally well.

To collect and keep items of importance to the child's life.

To provide age appropriate toys, books, and activities.

To notify foster parents of allegations, a hold on home, or decision to revoke license.

To provide respite care for up to 7 days every 6 months or plan for alternative care for child.

To maintain 24 hour a day availability (Careline).

To respond to foster parents communications in a timely fashion and act promptly on requests made on child's behalf.

To schedule opportunities for contact with birth family in order to meet mandate to reunify.

To give the child honest information about planning decisions.

To make reasonable efforts to assist the birth family towards the return of the child.

To prepare adolescents for independent living.

Source: DCF policy manual, Vol. II, chapter 41.

APPENDIX D
AGENCY RESPONSE AND LPRIC COMMENT

DEPARTMENT
of CHILDREN
and FAMILIES

JOHN G. ROWLAND
Governor

LINDA D'AMARIO ROSSI
Commissioner

Caring for Connecticut's Future

January 29, 1996

The Honorable Eileen M. Daily
The Honorable Ann P. Dandrow
Co-Chairpersons
Legislative Program Review and Investigations Committee
Room 506
State Capitol
Hartford, Connecticut 06106

Dear Senator Daily and Representative Dandrow:

Thank you for the opportunity to comment on the Legislative Program Review and Investigations Committee's report on the state's foster care system. A copy of the Department of Children and Families' comments are enclosed.

I would like to thank the committee for embarking on this study. Special thanks are due to the committee staff, especially Renee Muir, Michelle Castillo and Spencer Cain, for their diligent efforts in the production of a meaningful report. The Department shares your concern for Connecticut's foster care system and is committed to the implementation of the majority of your recommendations.

I look forward to working with both of you and LPRIC in the future.

Sincerely,

Linda D'Amario Rossi
Commissioner

LDR\jh
Enclosure

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DEPARTMENT
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JOHN G. ROWLAND
Governor

LINDA D'AMARIO ROSSI
Commissioner

Caring for Connecticut's Future

January 29, 1996

The Honorable Eileen M. Daily
The Honorable Ann P. Dandrow
Co-Chairpersons
Legislative Program Review and Investigations Committee
Room 506
State Capitol
Hartford, Connecticut 06106

Dear Senator Daily and Representative Dandrow:

Thank you for the opportunity to comment on the Legislative Program Review and Investigations Committee's report on the state's foster care system. A copy of the Department of Children and Families' comments are enclosed.

I would like to thank the committee for embarking on this study. Special thanks are due to the committee staff, especially Renee Muir, Michelle Castillo and Spencer Cain, for their diligent efforts in the production of a meaningful report. The Department shares your concern for Connecticut's foster care system and is committed to the implementation of the majority of your recommendations.

I look forward to working with both of you and LPRIC in the future.

Sincerely,

Linda D'Amario Rossi
Commissioner

LDR\jh
Enclosure

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Department of Children and Families'
Response to the
Legislative Program Review and Investigations Committee
Report on Foster Care

Overall, the Department of Children and Families concurs with the Legislative Program Review and Investigations Committee (LPRIC) Report on Foster Care conducted during the latter half of 1995. In many respects, the report confirms the Department's own findings in regard to its foster care system. The recommendations, in most instances, are consistent with actions the Department has already initiated.

The Department notes that some of the data used by the Legislative Program Review and Investigations Committee was based on automated DCF counts, which did not turn out to be accurate. A subsequent manual count showed lesser numbers which, while confirming some themes of the report, indicated problems of lesser magnitude.

As the Committee knows, the Department has been engaged in a five year process of updating its data collection system with a new state of the art management information system. That initiative will come to fruition in July of 1996 when the Department implements a single statewide computer system now referred to as LINK.

The following are responses to each of the report's recommendations.

Recommendation # 1: The LPRIC recommends that "A Division of Child Placement shall be created along with the restructuring of the child protection responsibilities into the proposed Division of Child Welfare Services. These two divisions, along with the current Division of Administrative Support, would administer the agency."

Response: Noting the issues in foster care, as well as other Department organizational issues, Commissioner Linda D'Amario Rossi engaged the firm of KPMG Peat Marwick, LLP, to conduct an organizational study of the Department.

The report, completed on October 16, 1995, included major recommendations for restructuring the Department's Central Office.

The report recommends the creation of an Office of Child Welfare Services which would consolidate all Protective and child placing services, including foster and adoption services. To be headed by a Senior Manager for Child Welfare Services, the Office is also recommended to have a new Assistant Manager position. The Assistant Manager will have direct administrative responsibility for day-to-day supervision of the regional offices and all foster and adoptive family training and support activities.

The foster and adoptive training and support activities shall include:

- recruitment, training, and licensure of foster and adoptive families as well as certifying relatives

- matching services for all child placements with foster and adoptive parents and relatives

- the provision of contract management performance monitoring of all private foster care resources, and

- ongoing technical support to the Connecticut Association of Foster and Adoptive Parents in association with Training Academy staff in designing a staff training module based upon good placement principles and practices.

This structure would create a consolidated place for foster care and adoption services, effectively meeting the spirit and purpose of the Committee's recommendation.

Recommendation # 2: It is recommended that, "The Department of Children and Families shall develop and implement the use of a child placement portfolio."

Response: DCF has designed this placement portfolio to be part of the forthcoming LINK computer system. In addition, the Department is returning to the past practice of creating prepared placement packets available to worker who would be placing children.

These packets will include: name; birth date; language; religion of the child; names of parent(s) and sibling(s) or significant others; copies of necessary documentation such as birth certificate, Social Security number, medical identification card; reason(s) for placement and legal status; goal of placement including the expected length of stay; copy of the service plan; copy of the visitation plan; an updated health passport; the name and telephone number of the assigned Social Worker and supervisor, the child's attorney, any educational surrogate; and if available, a recent photograph of the child.

The packet will also contain appropriate historical and background information for the foster parent or relative or others; a profile of the child including characteristics, special behaviors, likes, dislikes; a summary of rights and responsibilities of the foster parent/relative, foster child, birth family and DCF; a description of the Connecticut Foster and Adoptive Parent Association, contact person, Careline, support group meeting locations, etc.; any other information essential for the proper care of the child.

Current data can be entered onto the appropriate forms and the entire packet taken with the child at the time of placement. Copies of pertinent data will be kept in the case record as appropriate.

Recommendation # 3: It is recommended that, "The Division of Quality Assurance shall have the same responsibilities for relative certification as it does for licensing regular foster family homes, including final approval authority."

Response: The Department does not believe this recommendation will serve to enhance the certification process at this time. The current process is scattered in many places, does not allow for ownership and accountability or responsibility, and does not serve the Department, foster parents, relatives or children well.

In order to solve these problems, the Department is planning to conduct all family licensing and certification activity at the regional office level with specific assigned foster care workers. New procedures to control payments to unlicensed families, including relatives, have been implemented. A copy of the new procedures is in the Appendix.

The Department plans to conduct an assessment of the current relative certification process. Subsequently, new policies and procedures will be issued to ensure consistency among regional offices.

Recommendation # 4: It is recommended that "The investigation of abuse and neglect allegations against licensed foster care providers shall be conducted by the regional child protection staff who investigate all other abuse and neglect allegations. The investigations shall be completed within 14 days of referral to Careline."

Response: The Department concurs with this recommendation and has already begun the planning process to transfer the investigation of abuse and neglect allegations against licensed family care providers to the regional offices by February 1, 1996.

Procedures will mandate that licensed homes be put on hold once an investigation has begun, that no other children be placed in the home during that time, and the provider shall be immediately notified by the protective service investigator of the nature of the allegation and the hold on their license. At the end of the investigation period, the protective service investigation staff shall produce a finding that the allegation has either been substantiated or not substantiated. If the allegation is not substantiated, the hold is removed and the license is activated. If the allegation is substantiated, there may be a recommendation for license revocation or a request for follow-up by the FTSU staff to see that licensed providers comply with all recommendations.

Recommendation # 5: It is recommended that "To improve the existing working relationship between foster parents and DCF, the department shall clearly define the value and role of the foster parent in the foster care system in policy and procedure. The department shall communicate the change in policy to its staff and insure that compliance is carried out in case management and social work practice."

Response: The Department concurs with this recommendation. In fact, this might be the most significant recommendation of the report. The Department will redraft policy and procedures with an emphasis on the value the Department places on foster parents. It will stress the foster parent as part of a team concept in serving the child and family; emphasize workers' responsibilities to foster parents; and institute measures to hold workers and supervisors accountable to these principles and practices.

The Department has already entered into a contract with the Connecticut Foster and Adoptive Parent Association for approximately $700,000 per year which will make real the discussion of partnership. The contract allows for the Association and its members to become true members of the team in developing training and support for foster parents and workers.

In addition, the Department has instituted a major effort in joint training with foster parents and Department protective service workers. This training which is an effective parenting course has a 12 week curriculum, which, in addition to imparting skills to staff and foster parents, places a major focus on working together as a team to serve the child and family.

Additional Comments:

Utilization of Licensed Beds; Over Bed Capacity Placements: The Department's Division of Information Systems has been working on the creation of an accurate computer report which shall summarize essential information on the utilization and availability of beds in licensed and certified homes. Preliminary data is now being forwarded to regional FTSU units on a monthly basis. Regional management is required to report monthly on utilization. This effort is an interim process to control placements until LINK is operational in July of 1996.

Unlicensed Homes/Uncertified Relatives: Central Office and regional office management has been working to determine the reasons for unlicensed/uncertified placements and to reduce the number of placements.

As of the end of December 1995, the Department had reduced the number of unlicensed/uncertified placements.

Region	Number of "Unlicensed Vendors"	Number of Payments/Children in Placement
I	17	22
II	72	122
IV	71	112
III	16	21
V	43	63
VI	46	66
Total	265	406

The Department has taken the following steps to eliminate the issues of placements in unlicensed homes:

- new procedures have been developed for both the region and child welfare accounting which will control payments to unlicensed vendors effective January 16, 1996

- special efforts have been made to ensure that relative certifications (in which payments are allowed for 45 days while applications are pending) are completed in the appropriate timeframes. No payment will be allowed where an application for certification has not been taken and processed.

Frequency of Social Work Contacts with Child: The Department will reissue its policy to reinforce contacts with children. The Department has also put into place a system of monitoring these contacts and holding supervisors and managers responsible for carrying them out.

A Note on the Data:
Obviously, the Department is concerned about over-capacity of foster homes and use of unlicensed beds. The preliminary numbers compiled by the Committee from an automated DCF count seemed high to us. A manual count was ordered. The manual numbers are lower than the numbers presented by the Committee (for example, 265 unlicensed homes compared with 501), but the themes of concern remain valid. We are working to get all beds licensed. However, this cannot happen overnight, given the increasing number of children and families reported to the Department over the past nine months.

It should also be noted that the term 'unlicensed' might be overstated in some cases. Provisional is a term often used by other states to describe similar conditions -- for example, a home awaiting final licensure because written documentation from a third

party is en route. We should also note that many of the unlicensed homes are relatives of children who are awaiting certification.

Realistically, some of the over-capacity looks worse than it really is. For example, placement of sibling groups sometimes puts a home over capacity, but it is invariably better for children to keep brothers and sisters together if it is safe, rather than to separate them because of a technical capacity violation. Problematic, yes, but not always a superseding problem.

We are working to bring all unlicensed beds into the licensed fold. Preliminary reviews by social workers have identified what are believed to be good homes. The licensing process, which takes some time, is validation of this.

Corrections

The LPRIC report states, on page 36, the Department has developed a 12 hour training course for both foster parents and protective service social workers. The training program is a 12 week program, meeting for three hours a week, for a total of 36 hours. All regions have offered the group in the Fall of 1995, and are presently in the process of organizing new groups.

Page 37 states that we have not developed or provided post-licensing training for foster parents. A post-licensing curriculum has been developed and has been running consistently since the spring of 1994.

DEPARTMENT
of CHILDREN
and FAMILIES

JOHN G. ROWLAND
Governor

LINDA D'AMARIO ROSSI
Commissioner

Caring for Connecticut's Future

MEMORANDUM

TO: Regional Administrators
FTSU Managers
Dale Maynard, Director, Policy Division
Pam Nelson, Child Welfare Accounting
Bob Budney, Director of Licensing

FROM: Sharon A. Martin SM 1/2/96
Deputy Commissioner

DATE: December 29, 1995

RE: Pre-LINK Procedures for Requesting a Vendor Number

In order to reduce the number of unlicensed vendors which are receiving payments and to ensure that accurate data is entered in the Vendor Payment System, the following procedures shall be effective Tuesday, January 16, 1996.

All requests for a vendor number for a foster care or adoption license or for a relative certification **must be:**

- processed by the assigned FTSU Office Assistant **only**
- accompanied by a signed and dated application for licensure or certification
- submitted to Child Welfare Accounting on CYS-455, "Vendor Registration" with the numerical code for vendor type included, and
- signed by a FTSU supervisor or the FTSU Program Supervisor.

Child Welfare Accounting shall:

- assign a vendor number, and
- enter the vendor type numerical code on the license screen.

Note: Child Welfare Accounting shall return any incomplete vendor registrations to the FTSU Office Assistant.

Upon receipt of the assigned number, the FTSU Office Assistant shall enter the license/certification status and effective date.

For Completed Relative Certifications:

All completed relative certifications must be reviewed and approved by the FTSU Program Supervisor. Upon approval, the FTSU Office Assistant will enter the certification status and certification date in the VPS.

For Special Study Foster Parents only:

The FTSU Office Assistant shall write the word "INACTIVE" next to the check-off box for special studies on the CYS-455. Child Welfare Accounting shall assign a vendor number to the family, as usual, but will designate the number as "inactive" which shall disallow payment to the family until notified by Q.A. Licensing that a license has been authorized and is being issued.

Note: An administrative exception to allow a payment prior to licensure shall only be granted by the Deputy Commissioner for Programs.

For Non-Family Vendors (businesses, sheriffs, residential facilities, day care, etc.):

Requests for these types of vendor numbers shall continue to be processed and submitted to Child Welfare Accounting by the non-FTSU data entry operators. The D.E.O.'s must also include the numerical code for vendor type.

Notification to Regional Offices of Assigned Vendor Numbers:

Child Welfare Accounting shall return <u>all</u> CYS-455's with assigned vendor numbers to the FTSU Office Assistants, who will be responsible for distributing the cards to the requesters within the regional office and sub-offices.

Tickler Controls on Relative Certification Applications:

The FTSU Program Supervisor shall ensure that a forty calendar day tickler control is established to identify relative certification applications that have not been processed within the forty-five day period and to notify the appropriate Program Supervisor of the need for a decision to be made on the application.

Regional Managers are responsible for monitoring the compliance with these procedures.

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Required Contacts During an Investigation

Policy

During an investigation, specific procedures shall be followed regarding who will be interviewed, within what timeframes, and under what conditions.

Whenever possible, parental cooperation and involvement will be sought throughout the investigation.

Purpose

Consistent and sustained efforts to accomplish contacts are necessary in order to

- respond to immediate child protection issues, and
- complete a timely and comprehensive investigation and assessment.

Documentation of Contacts

The worker shall include documentation in the case record of the following:

- contacts completed
- attempts to make contact
- supervisory decisions regarding contacts.

Contacts During Initial Stage of Investigation

The initial stage of the investigation shall include a face-to-face contact with

- the child, and
- the parent or person responsible for the child's welfare.

Contacts During On-going Investigation

The on-going investigation shall include the following contacts, as appropriate to the child:

- day care personnel
- pre-school or school personnel
- the child's medical provider
- any community service provider known to be providing services to the family currently or within the previous twelve months
- relatives, neighbors or police when evidence indicates they may have information pertinent to the investigation.

The worker shall document in the case record any circumstances which make it inappropriate to contact any of the above individuals.

Required Contacts During an Investigation

Contact with the Child

If the child is in imminent danger, the worker shall make every effort to see the child immediately.

In all situations, the child shall be interviewed apart from the parent or person responsible for the child.

If the child is in the home, the child shall be interviewed alone.

If the parent refuses entry into the home and there is reasonable cause to suspect that the child is in danger, the worker shall contact the police and request assistance.

Cross-reference: *See policy 34-6, "Entrance to Client's Home".*

Contact with Other Children

All children in the home and, if appropriate, any other children of the parent or person responsible who do not reside in the home, shall be seen within three working days of the start of the investigation.

If the worker is unable to interview the children within this timeframe, continued efforts shall be made to interview them in a timely manner until a supervisory conference decision determines that no additional attempts are required.

Contact with Parent or Person Responsible

In cases coded as imminent danger, emergency and severe, the first face-to-face contact with the parent or person responsible shall be unannounced.

If the worker is unable to make face-to-face contact, supervisory consultation is required.

Inability to Complete Contact with Parent or Person Responsible

When the worker is unable to complete a face-to-face contact with the parent or person responsible, the procedures are as follows:

In imminent danger, emergency or severe cases, the worker shall

- make daily attempts to accomplish such contact
- notify his/her supervisor of inability to make contact and any other problems in conducting the investigation.

Required Contacts During an Investigation

Inability to Complete Contact with Parent or Person Responsible

In non-severe cases, the worker shall

- attempt to make face-to-face contact every two working days until a supervisory consultation determines that no additional attempts are required.

All such attempts and decisions shall be documented in the case record.

Whereabouts Unknown of Parent or Person Responsible

If the parent or person responsible is not at home at the time of the investigation visit, all reasonable efforts must be made to contact them within twenty-four (24) hours.

If their whereabouts are unknown, the worker shall make reasonable efforts to locate them by contacting any or all of the following:

- relatives
- medical providers
- school systems
- day care provider
- state/local police
- post office
- telephone directory
- known employers
- Dept. of Corrections
- Dept. of Mental Health
- Dept. of Motor Vehicles
- Dept. of Social Services
- Social Security
- others as appropriate per supervisory conference

Parent or Person Responsible Out-of-State

If the parent or person responsible is out-of-state and their location is known, the social worker shall attempt to make contact with the out-of-state child protection agency within one working day.

If, during the course of the investigation, the family moves out of the region or out-of-state, a referral shall be sent to the appropriate region or proper out-of-state authorities.

ADDENDUM

Legislative Program Review and Investigations Committee Comments on Department of Children and Families Response

Page D-2, Recommendation #1 (Organizational Structure): The program review committee maintains that DCF needs to clearly focus on the placement of children in foster care. While the committee concurs with many of the findings of the department and of the consultant's (KPMG Peat Marwick LLP) management study, it differs on the needed organizational design to improve the agency's functioning with regard to out-of-home placements for children. The changes proposed by DCF and the consultant do little to improve the current administrative and organizational design of the foster care program.

Page D-3, Recommendation #2 (Child Placement Portfolio): While DCF has indicated it will implement this recommendation, the committee stresses the importance of providing the completed child placement portfolios to foster care parents and providers.

Page D-4, Recommendation #3 (Relative Certification): The committee agrees with the department's position that recruiting and assessment functions of relatives and foster parents is best done at the regional level. However, the program review committee believes the final approval of relative certification and foster care licensing must be centralized to ensure they meet the department's regulations and standards. Also, the department's proposed changes do not address the questionable practice of placing children in uncertified and unlicensed homes.

Page D-4, Recommendation #4 (Investigation Process): While DCF has indicated it will implement a portion of this recommendation by transferring the investigation function to the regional offices, it is not clear as to which unit (regional or central office) has the authority for making or enforcing recommendations based on the outcome of the investigation. The committee's recommendation clarified for DCF staff and foster parents the confusing process of investigating allegations of abuse and neglect against foster care providers.

Page D-6, Frequency of social work contacts with child: The committee acknowledges the department's reissued policy for social work contact with the child and holding supervisors and managers accountable for compliance with policy is crucial during the protective services investigation period. However, the committee believes frequent contact between the child and DCF social worker must continue *throughout* the case management, including the time the child is placed in foster care. Social work contact with foster children is critical to child protection and family reunification goals and mandated by policy.